

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9792 CERTIFICATE OF DEATH

89763

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Grand Ave.				d. STREET ADDRESS 201 Grand Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rudolph LeGard Appell	First	Middle	Last	4. DATE OF DEATH Sept. 1, 1960	Month	Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1915	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Martinsburg, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clifton A. Appell			14. MOTHER'S MAIDEN NAME Oddie L. Bevins				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes War II		16. SOCIAL SECURITY NO.		17. INFORMANT Betty Ann Appell 201 Grand Ave. (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>708 Montgony Ave. Cumberland</i>		(County)	(State)
21. I certify that I attended the deceased from <i>8 May 1960</i> to <i>1 Sept 1960</i> , that I last saw the deceased alive on <i>1 Sept 1960</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>David T. Rees</i> ADDRESS (Street, city or town, state) <i>708 Montgony Ave. Cumberland</i> DATE SIGNED <i>1960</i>							
PHYSICIAN'S NAME (Type) David T. Rees 708 Montgomery Ave. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-4-60	22c. NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Scappelli, Cumberland, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

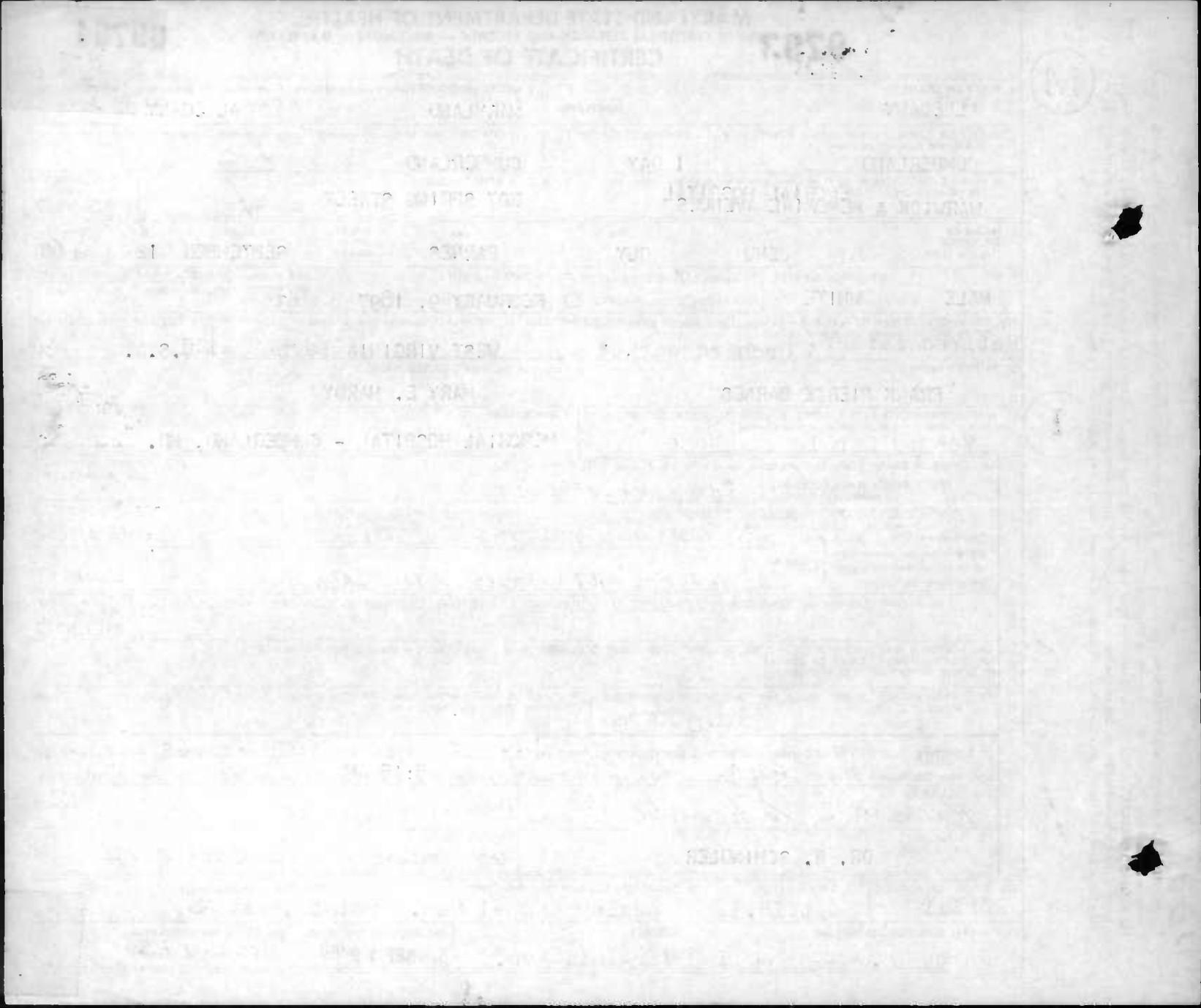
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9753

09764

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS 207 SPRING STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JEHU	Middle GUY	Last BARNES
4. DATE OF DEATH	Month SEPTEMBER	Day 12	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 9, 1897
9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 63	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Orchard worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? Barnes M. U.S.A.
13. FATHER'S NAME FRANK PIERCE BARNES	14. MOTHER'S MAIDEN NAME MARY E. HARDY	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON INTERVAL BETWEEN ONSET AND DEATH 1 YR.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASIS TO LUNGS AND LIVER 4 MONTHS			
Due to (c) PANCREATIC METASTASIS WITH JAUNDICE 2 WKS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 27 1960 to SEPT 13 1960 , that (I) (we) last saw the deceased alive on AUG 7 1960 , and that death occurred at 5:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Richard E. Schindler		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. R. SCHINDLER		22d. ADDRESS 69 GREENE ST CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 15, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.	23d. LOCATION (City, town, or county) (State) Points, West Va.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli	ADDRESS 108 Virginia Ave.	25a. REC'D BY REGISTRAR DATE SEP 19 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09765

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1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 21 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 679 FAYETTE STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - MEMORIAL AVENUE						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First NETTIE	Middle VIRGINIA	Lost	4. DATE OF DEATH SEPTEMBER 27 1960	Month	Day	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BERKELEY SPRINGS, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN W. GROVE		14. MOTHER'S MAIDEN NAME SARAH HOVERMALE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and/or (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X		DUE TO <i>anterior</i> thyroid with extensive metastasis to lungs.				6 months		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 26 Sept 1960 , and that death occurred on 27 Sept 1960 , at 3:20 AM the causes and on the date stated above.								
22a. SIGNATURE <i>W. Alfred Van Ormer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 SO. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 30, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. George,</i>		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR OCT 3 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09766

9795		CERTIFICATE OF DEATH									
1. PLACE OF DEATH o. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 49 DAYS								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND								
3. NAME OF DECEASED (Type or print) MARY		First MARY	Middle E.	Lost	4. DATE OF DEATH SEPTEMBER 7 1960	Month SEPTEMBER	Day 7	Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1889	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Retired Custodian, Alleg. High School		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARTINSBURG, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME GEORGE W. ALBERT		14. MOTHER'S MAIDEN NAME IDA SUSAN RAINES		Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Metastatic Carcinoma - Bladder</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 months.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CUMBERLAND		(County) CUMBERLAND		(State) MARYLAND	
21. I certify that (I) (this hospital) attended the deceased from Sept 7 1960 to Sept 19 1960 , that (I) (we) lost saw the deceased alive on Sept 7 1960 and that death occurred at 4:00 A.M. M, from the causes and on the date stated above.									22b. DATE SIGNED 9/18/60		
22a. SIGNATURE <i>John J. Hafer</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS 133 1/2 Ave, Cumberland, Md.							
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT		23. NAME OF CEMETERY OR CREMATORIUM St. Peter & Pauls Cemetery					23d. LOCATION (City, town, or county) Cumberland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/9/1960		23c. ADDRESS John J. Hafer, Cumberland, Maryland					23d. LOCATION (City, town, or county) Cumberland, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland						25a. REC'D. BY REGISTRAR SEP 19 1960			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hafer</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09767

9796

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle H.	Last BOND
4. DATE OF DEATH	Month SEPTEMBER	Day 23	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1887
9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	11. KIND OF BUSINESS OR INDUSTRY P.E. Sub-Station	12. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND
13. FATHER'S NAME THOMAS BOND	14. MOTHER'S MAIDEN NAME LUCILLA APPLEDORE	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 274-10-4711A	
16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arterio Ollervodio vascular disease 45000 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause first. (b) DUE TO (c) Complicated by acute heart failure + uremia.		Since 2-11-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Gastric resection for penetrating (9-17-60) saddle ulcer	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 9-17-60		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-16-60 to 9-23-60 , that (I) (we) last saw the deceased alive on 9-22-60 and that death occurred at 12:35 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 9-26-60	
22a. SIGNATURE W. F. Williams	22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-25-60	23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	23d. LOCATION (City, town, or county) Frostburg, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Duret	ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE SEP 26 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Knob

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2011 RELEASE UNDER E.O. 14176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09768

Item 4 FilmG271 9-15-60 et

Reg. Dist. No.

979

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 75 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 782 MacDonald Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle BUCHANAN	4. DATE OF DEATH Month Day Year Sept. 1, 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH March 28, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Rhoads		14. MOTHER'S MAIDEN NAME Catherine Poister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles R. Nuzum, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED SEPT. 1, 1960		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 3, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Mausoleum	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR SEP 6 60	24b. REGISTRAR'S SIGNATURE <i>✓</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09769

9798		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS RT. #1							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		85X-3									
3. NAME OF DECEASED (Type or print)		First THOMAS Middle Marvin Last CARDER		4. DATE OF DEATH SEPTEMBER 22 1960							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 26, 1897		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED carman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.		11. BIRTHPLACE (State or foreign country) POINTS, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALBERT CARDER				14. MOTHER'S MAIDEN NAME BETTY HUTSON Elizabeth J. Watson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Years, rank or grade or dates of service) Yes		16. SOCIAL SECURITY NO. W. W. I		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs, metastatic, primary 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO site unknown						6 mos			
(b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema. Cor pulmonale										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1 - 23 1954 to 9 - 22 1960 that (I) (we) last saw the deceased alive on 9 - 21 1960 and that death occurred at 2:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Laer L. Ballin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-23-60					
22c. PHYSICIAN'S NAME (Type) DR. BALLIN		22d. ADDRESS 62 Greene St. Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 25, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.		23d. LOCATION (City, town, or county) Points, W. Va.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

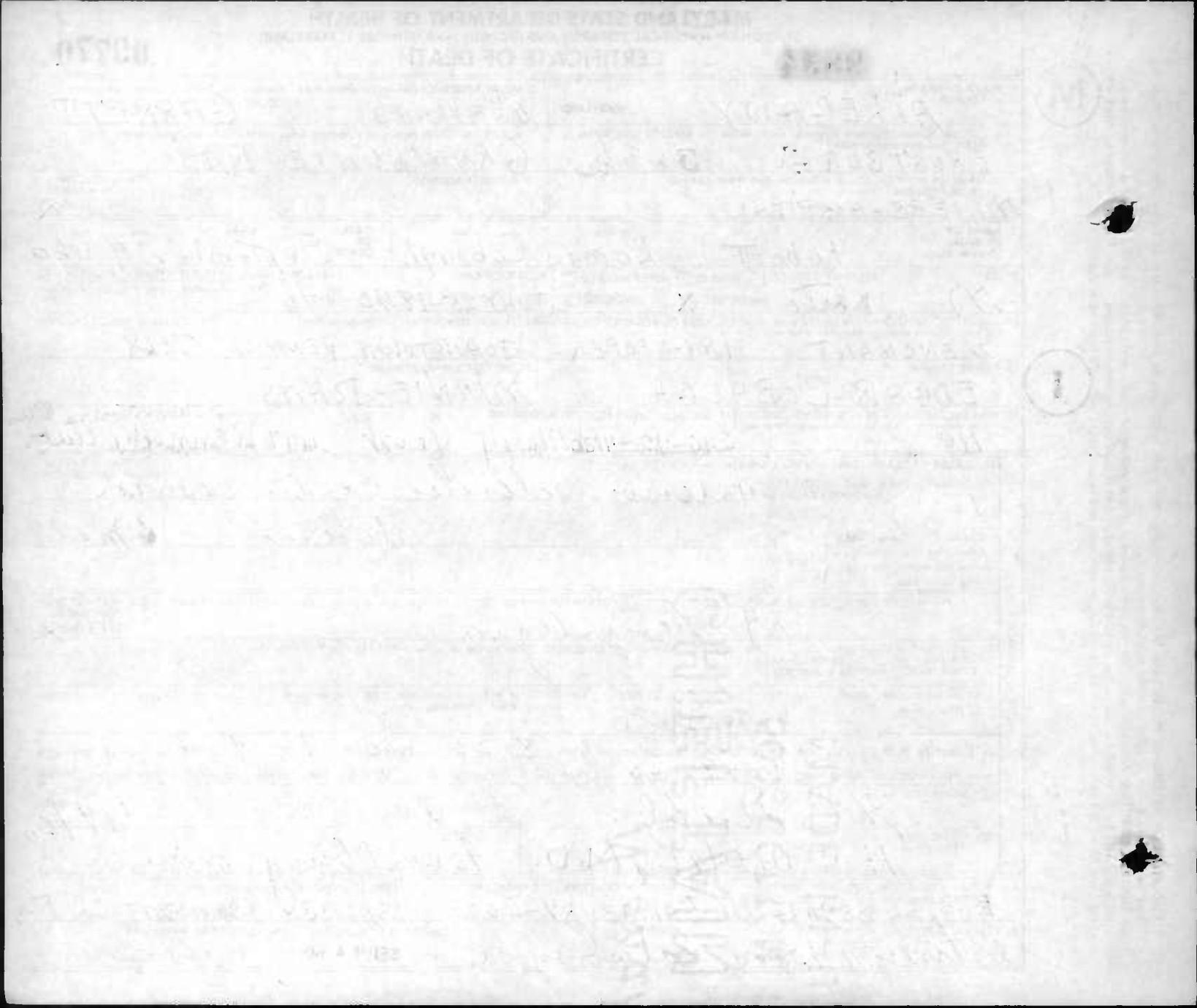
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9834

CERTIFICATE OF DEATH

09770

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS-HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE - RD.	
d. STREET ADDRESS 		d. STREET ADDRESS 	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11X-2	
3. NAME OF DECEASED (Type or print) Robert Loman Cobough		First	Middle
Last		4. DATE OF DEATH September 9 1960	Month Day Year
S. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25-1890
9. AGE (in years last birthday) yrs. 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT	11. KIND OF BUSINESS OR INDUSTRY INN-KEEPER	12. BIRTHPLACE (State or foreign country) JOHNSTOWN, PENNA.
13. FATHER'S NAME EDGAR-COBOUGH	14. MOTHER'S MAIDEN NAME MINNIE-JOHNS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 240-42-4136	17. INFORMANT Mary Jeek	Address Johnstown Pa. 447 Kennedy Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-vascular DUE TO 422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) disease INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rt. hemiplegia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Doy. Year 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-20 1960 to 9-9 1960 that (I) (we) last saw the deceased alive on 9-9 1960 and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE H.C. Dietl,		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/9/60
22c. PHYSICIAN'S NAME (Type) H.C. Dietl, M.D.		22d. ADDRESS frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL SEPT. 12-1960	23b. DATE THEREOF SEPT. 12-1960	23c. NAME OF CEMETERY OR CREMATORIUM SALISBURY F.O.O.F.	23d. LOCATION (City, town, or county) (State) SALISBURY-SOMERSET Co. PA.
24. FUNERAL DIRECTOR'S SIGNATURE Stanley Thomas, Salisbury, Pa.		ADDRESS 	25a. REC'D BY REGISTRAR DATE SEP 14 '60
			25b. REGISTRAR'S SIGNATURE Albert S. Haas



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09771

9799

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/25/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret E. Couter		First	Middle
		Last	
4. DATE OF DEATH September 26, 1960		Month	Day
		Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
13. FATHER'S NAME William Wright		14. MOTHER'S MAIDEN NAME Joann Zimmerly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT P. O. Box 599, Address Cumberland, Md. Allegany County Infirmary Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 592X (b) General arteriosclerosis, DUE TO (c) Chronic nephritis INTERVAL BETWEEN ONSET & DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile deterioration.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/25/56 19... to 9/26/60 19..., that (I) (we) last saw the deceased alive on 9/24/60 19..., and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <i>James E. McLean</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 9/26/60
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/1960	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE SEP 29 '60
			25b. REGISTRAR'S SIGNATURE Arthur L. Trahan

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09772

9801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8 mos. 24 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat				d. STREET ADDRESS 346 Central Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milford		Middle Luther		Last Crabtree		4. DATE OF DEATH September 23	Month Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/81		9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Gilpintown U.S.A.	
13. FATHER'S NAME Henry Crabtree		14. MOTHER'S MAIDEN NAME Kathleen Springstead					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT William M. Crabtree, Cumberland, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492 Primary atypical pneumonia 290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 412 Chronic myocardial degeneration ? DUE TO (c) 290 Pneumonia, acute ?		INTERVAL BETWEEN ONSET AND DEATH 7 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Simple psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec. 30, 1959	(County) (State) Sept. 23, 1960
21. I certify that I attended the deceased from Dec. 30, 1959 to Sept. 23, 1960 , that I last saw the deceased alive on Sept. 22, 1960 , and that death occurred at 3:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md.					
ACTUAL SIGNATURE James E. McLean		DATE SIGNED 9/23/60					
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/60		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 27 '60					
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09773

9831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Midland		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Raymond	Middle Payne	Last Cutter	4. DATE OF DEATH	Month September	Day 14	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 26, 1918	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Allegany Ballistics Laboratory		12. CITIZEN OF WHAT COUNTRY? Midland, Maryland U.S.A.			
13. FATHER'S NAME Russell Cutter		14. MOTHER'S MAIDEN NAME Helen Stewart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 220-10-1392		17. INFORMANT Mrs. Raymond Cutter		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden							
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis with Thrombosis, Left ----							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. O. McLane	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Sept. 14, 1960
EXAMINER'S NAME (Type) W. O. McLane, Jr. M.D.	Asst. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9.16/60	22c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Clinton S. Evans	

STATEMENT OF CHARGE - STATEMENT OF CHARGE
EXHIBIT - MEDICAL EXAMINER'S CERTIFICATE TO DEATH

100

NAME OF PERSON

ADDRESS

TELEPHONE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. File page 4 with the registrar to burial, cremation, or removal.

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VS. A15ME(S)
SM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09774

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barten		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
		d. STREET ADDRESS Douglas Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First STANLEY	Middle LUTHER	Last DAVIS
4. DATE OF DEATH	Month 9/16/1960	Day 19	Year
S. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27/10/22
9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Barton, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Davis		14. MOTHER'S MAIDEN NAME Jane Kirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 2nd. World War 215-14-6385	
17. INFORMANT Mrs. Stanley Davis, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH SUDDEN--	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		CORONARY OCCLUSION (WIFE)	
DUE TO (c)		CORONARY SCLEROSIS WITH THROMBOSIS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED Sept. 16, 1960		
EXAMINER'S NAME (Type) Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/19/1960	22c. NAME OF CEMETERY OR CREMATORIUM MT. VIEW CEMETERY	22d. LOCATION (City, town, or county) (State) MOSCOW, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN	ADDRESS LONACONING, MD.	24a. REC'D BY REGISTRAR DATE SEP 19 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINERS CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Cause of Death	
John G. Jones		1900-01-01		Diseased	
Address		City, State		County	
123 Main Street Anytown, USA		Anytown, USA		Any County	
Relationship to Deceased		Signature		Date	
Son		John G. Jones		1900-01-01	
Occupation		Signature		Date	
Laborer		John G. Jones		1900-01-01	
X		X		X	
Signature of Physician		Signature of Hospital		Signature of Coroner	
John G. Jones		John G. Jones		John G. Jones	
Anytown, USA		Anytown, USA		Anytown, USA	
1900-01-01		1900-01-01		1900-01-01	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
IN OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**
CERTIFICATE OF DEATH

09775

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1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) J. Owen Deffenbaugh		First	Middle	Last	4. DATE OF DEATH September 24th, 1960	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Oct. 26th, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY C&PRR		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John G. Deffenbaugh		14. MOTHER'S MAIDEN NAME Jane Hitchins		15. SOCIAL SECURITY NO. 712-14-1700					
16. SOCIAL SECURITY NO. 712-14-1700		17. INFORMANT Mrs. Roy F. Growden, Mt. Savage, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerosis		DUE TO (b) Arth Suppurative Cholecystitis		DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 13 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sept. 12, 1960		(County) Sept. 24, 1960	(State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Sept. 24, 1960 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Hilda J. Walters		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Hilda J. Walters,		22d. ADDRESS " 48 Broadway, Frostburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-60		23c. NAME OF CEMETERY OR CREMATORIUM M. E. Cemetery		23d. LOCATION (City, town, or county) Mt. Savage, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR SEP 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										09776				
9801					CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN lb 10 DAYS					b. COUNTY MINERAL				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH	Month	Day	Year					
ALONZO				WISE	DORSEY	SEPT. 9, 1960								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MALE WHITE		8. DATE OF BIRTH		9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> Months 1 Days 0 Hours 0 Min. 0				
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-28-95								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Caller					10b. KIND OF BUSINESS OR INDUSTRY W.MARYLAND R.R.					11. BIRTHPLACE (State or foreign country) MARYLAND, Hagerstown				
										12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ASHBY DORSEY					14. MOTHER'S MAIDEN NAME Clara Proctor									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.					16. SOCIAL SECURITY NO.					17. INFORMANT Richard Dorsey 34 Knobley St., Ridgeley				
										Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<i>Armenia due to hypertension C.V. disease, partial hemiplegia & anemia</i> 2 months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 1960 to Sept 9, 1960 , that (I) (we) last saw the deceased alive on July 1960 and that death occurred at M. from the causes and on the date stated above.														
22a. SIGNATURE B. M. Schindler					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>					22b. DATE SIGNED 9/9/60				
22c. PHYSICIAN'S NAME (Type) DR. B.M. SCHINDLER					STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORIAL				
Burial					9/11/60					Hillcrest Burial Park				
										23d. LOCATION (City, town, or county) (State) Cumberland, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George										ADDRESS Cumberland, Md.				
										25a. REC'D BY REGISTRAR DATE SEP 13 '60				
										25b. REGISTRAR'S SIGNATURE Arthur S. Trahan				

OTTER

PHOTO BY STARBUCK

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1932

OTTER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09777

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pgce 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hospital		e. STREET ADDRESS 34 Knobley St.	
3. NAME OF DECEASED (Type or print) Vivian		First Lee	Middle Dorsey
4. DATE OF DEATH September 9 1960	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1894
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Hoffman		14. MOTHER'S MAIDEN NAME Elda Crawthers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Richard Dorsey, 34 Knobley St. Ridgeley		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH SUDDEN -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 9, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park Cumberland, Md.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR Arthur S. Thorne	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne
		DATE SEP 13 '60	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9803

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 16 Film G271 9-23-60 et

09778

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb CUMBERLAND 12 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X ECKHART	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		MEMORIAL HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First PERRY	Middle DUDLEY	4. DATE OF DEATH	Month SEPT.	Day 17,	Year 1960
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 26, 1880	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY F' BG. FUEL CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DUDLEY		14. MOTHER'S MAIDEN NAME ELIZABETH LAMMERT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-01-3680		17. INFORMANT MRS. MARY DUDLEY, ECKHART, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>ARTERIOSCLEROTIC VASCULAR disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) DR. BENEDICT SKITARELIC		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-19-1960		22c. NAME OF CEMETERY OR CREMATORIUM ECKHART CEMETERY		22d. LOCATION (City, town, or county) (State) ECKHART, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. P. Guest</u>		ADDRESS FROSTBURG, MD.		24a. REC'D. BY REGISTRAR SEP 20 60		24b. REGISTRAR'S SIGNATURE <u>Elmer S. Knarr</u>	
VS. A15ME 5M 2/57				DATE			

ВІЗМОЛІДАЧНЯ ТО ВІДСТАВЛЕННЯ ОГЛАШУЮТЬ
ІЗДЕРЖКИ ПОДАЧІ СПІВВІДНОШИНІВ

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it **in pencil**, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09779

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Moscow		c. LENGTH OF STAY IN 1b 3 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 Mi W. of Moscow		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maurice Van Buren		First	Middle	Last	4. DATE OF DEATH Fazenbaker	Month	Day	Year
S. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1918	9. AGE (In years at birthday) 42 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
				Aug. 4, 1918				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber cutter		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Oliver C. Fazenbaker		14. MOTHER'S MAIDEN NAME Fanny Belle Grove						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Fazenbaker-Gilmore, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRAUMATIC ASPHYXIATION INTERVAL BETWEEN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COMPRESSION OF CHEST AND ABDOMEN 5 Min.								
DUE TO (c) Pinned under overturned tractor 5 Min.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned under overturned tractor								
20c. TIME OF INJURY Month, Day, Year Hour o. m. Sept 1 1960		20d. INJURY OCCURRED White of work <input checked="" type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Moscow		(County) Alleg. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>W. C. McLane</i>		DATE SIGNED Sept. 1, 1960						
EXAMINER'S NAME (Type) W. C. McLane, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> asst DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/60		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) Westernport (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. B.</i>		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

DEPARTMENT OF STATE QUARANTINE
DEPARTMENT OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09780

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle G.	Last Harriman
4. DATE OF DEATH	Month September	Day 17th, 1960	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26th, 1876
9. AGE (In years last birthday) 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Housework	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME Annie Glenn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Mrs. Michael Taccino, Frostburg, Md.	Address W. Main Street, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Arteriosclerotic Heart Disease	
20c. TIME OF INJURY Hour o. m. p. m. 19	Month JUNE	Day 19	Year 1960
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eckhart Cemetery	20f. (City or town) Eckhart	(County) Md.
21. I certify that I attended the deceased from JUNE 19, 1960 , to 9/12, 1960 , that I last saw the deceased alive on 9/12, 1960 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Martin M. Rothstein, M.D.</i>	ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-60	22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery
22d. LOCATION (City, town, or county) Eckhart, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.P. Durst</i>		24a. REC'D BY REGISTRAR SEP 22 '60	24b. REGISTRAR'S SIGNATURE <i>Charles S. Knapp</i>
ADDRESS Frostburg, Md.			

02708

СИБИРЬ ОБЩЕСТВО

СИБИРЬ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09781

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			e. STREET ADDRESS 620 ELWOOD STREET			
3. NAME OF DECEASED (Type or print)		First WALTER	Middle H	Last HUGHES	4. DATE OF DEATH SEPTEMBER 22 1960	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 14, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Bricklayer		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		
13. FATHER'S NAME JOSEPH HUGHES			14. MOTHER'S MAIDEN NAME MINTA JULIA DAMM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-8120		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 450-0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Pulmonary infarct (c) DUE TO Generalized arteriosclerosis (d) DUE TO Cardiac decompensation						INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1955 to Sept. 22 1960 , that (I) (we) last saw the deceased alive on Sept. 22 1960 , and that death occurred at 5:55 A.M. from the causes and on the date stated above.						22b. DATE SIGNED
22a. SIGNATURE George M. Simons		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) DR. G. M. SIMONS		22d. ADDRESS Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City, town, or county) Cumberland (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. V.P.L. Cumberland Md.		ADDRESS mgj.		25a. REC'D BY REGISTRAR DATE SEP 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause

M

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
				a. STATE Maryland	b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS Rt.3, M24, Bedford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MAYME Middle ALICE Last HURT		4. DATE OF DEATH SEPT. 16		Month Day Year		1960	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1895	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Own Home		12. BIRTHPLACE (State or foreign country) Fairhope, Pennsylvania	
13. CITIZEN OF WHAT COUNTRY? USA							
14. FATHER'S NAME Silas Shroyer				15. MOTHER'S MAIDEN NAME Martha Emerick			
16. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] If yes, give war or dates of service]				17. SOCIAL SECURITY NO. 18. INFORMANT Address			
Fred Hurt, M24, Rt.3, Bedford Rd., Cumberland				Md.			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 1 Hr.			
RUPTURE OF DISSECTING ANEURYSM				1 Hr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept. 16, 1960	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE SEP 20 '60		24b. REGISTRAR'S SIGNATURE Clinton S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09783

9806

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A15 (4)
M 9/59

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany				a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 12/29/51		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ethel	Middle J.	Last Hyde	4. DATE OF DEATH Month September 28, Day Year 1960
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 7/16/1893	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED: School Teacher - Teaching		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alfred J. Hyde		14. MOTHER'S MAIDEN NAME Catherine Mowbray		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b). DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Senile psychosis					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/29/51 19... to 9/28/60 19..., that (I) (we) last saw the deceased alive on 9/28/60 19 @ 6:33 P.M., and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE James E. McLean		22b. DATE 9/29/60			
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22e. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/60		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill	
24. FUNERAL DIRECTOR'S SIGNATURE El Boal		ADDRESS Westernport, Md.		23d. LOCATION (City, town, or county) Moscow	
				25a. REC'D BY REGISTRAR DATE OCT 3 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kline	

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ATLANTA COUNTY LIBRARIES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09784

9807

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Bowling Green)		c. LENGTH OF STAY IN 1b 5yrs Green	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Willard	First Madison	Middle Jeffries	Last 4. DATE OF DEATH Sept. 6 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1915
9. AGE (In years last birthday) 45 yrs.	10. BIRTHPLACE (State or foreign country) Cumberland, Maryland	11. IF UNDER 1 YEAR Months 0 Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Experimental		10b. KIND OF BUSINESS OR INDUSTRY Textile	
13. FATHER'S NAME Porter Jeffries		14. MOTHER'S MAIDEN NAME Eveline Marie Sharretts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-5274	
17. INFORMANT Ruth Jeffries		Address Bowling, Green Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, RIGHT			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS AND SCLEROSIS			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-60	22c. NAME OF CEMETERY OR CREMATORIUM Indian Mount Cem.	22d. LOCATION (City, town, or county) Romney, W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE SEP 13 '60
24b. REGISTRAR'S SIGNATURE <i>Charles L. Krause</i>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09785

9854

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Rural)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O2 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3, Bedford Road		d. STREET ADDRESS 417 N. Centre Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLEN		First SIMONS	Middle JOHNSON
4. DATE OF DEATH September 4		Last 1960	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 23, 1896		9. AGE (In years lost birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tube Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield Tire Co.	
11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Johnson		14. MOTHER'S MAIDEN NAME Clara Simons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 214-07-0753	
17. INFORMANT Mrs. Richard Kenney		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH Minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic cor pulmonale	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 19 55 , August 19 60 , that (I) (we) last saw the deceased alive on August 9, 1960 , and that death occurred at M , from the causes and on the date stated above.		22a. SIGNATURE G. Overton Himmelwright M.D.	
22c. PHYSICIAN'S NAME (Type) G. Overton Himmelwright M.D.		M.D. <input checked="" type="checkbox"/> ATTENDING MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 133 Va. Ave., Cumberland, Maryland	22b. DATE SIGNED 9/8/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 7, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City, town, or county) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland	25a. REC'D BY REGISTRAR DATE SEP 13 '60
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09786

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegheny																
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 711 Arundel St.																
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print)		First IDA	Middle MAT	Last JOHNSON	4. DATE OF DEATH JUNE 17, 1879	Month SEPT.	Day 21	Year 19 60														
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1879		9. AGE (in years last birthday) yrs. 81	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA																
13. FATHER'S NAME RICHARD JEFFERY'S				14. MOTHER'S MAIDEN NAME MELINDA SNYDER																		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT PATIENTS CHART		Address																
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 30%;">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</td> <td style="vertical-align: top; width: 40%;">congestive heart failure</td> <td style="vertical-align: top; width: 30%;">INTERVAL BETWEEN ONSET AND DEATH 8 weeks</td> </tr> <tr> <td style="vertical-align: top;">420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</td> <td style="vertical-align: top;">anterosclerotic heart disease</td> <td style="vertical-align: top;">6 mos</td> </tr> <tr> <td style="vertical-align: top;">DUE TO (b)</td> <td style="vertical-align: top;">generalized arteriosclerosis</td> <td style="vertical-align: top;">26 years</td> </tr> <tr> <td style="vertical-align: top;">DUE TO (c)</td> <td></td> <td></td> </tr> </table> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	congestive heart failure	INTERVAL BETWEEN ONSET AND DEATH 8 weeks	420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	anterosclerotic heart disease	6 mos	DUE TO (b)	generalized arteriosclerosis	26 years	DUE TO (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	congestive heart failure	INTERVAL BETWEEN ONSET AND DEATH 8 weeks																				
420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	anterosclerotic heart disease	6 mos																				
DUE TO (b)	generalized arteriosclerosis	26 years																				
DUE TO (c)																						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)																				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																
21. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that death occurred at 12:20 , from the causes and on the date stated above.																						
22a. SIGNATURE <i>L. Brings</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED																		
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, MD.		22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/24/60		23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		23d. LOCATION (City, town, or county) Oakland (State) Maryland																
24. FUNERAL DIRECTOR'S SIGNATURE <i>Gerald N. Minnich</i>		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE SEP 26 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>																

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RECEIVED TO READER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the funeral director, or by the hospital or attending physician if completely filled in. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10896

9809

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW		d. STREET ADDRESS <i>25X-2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.								
3. NAME OF DECEASED (Type or print)		First BABY	Middle BOY	Lost KAYLOR	4. DATE OF DEATH SEPTEMBER 14, 1960	Month SEPTEMBER	Day 14	Year 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPTEMBER 14, 1960	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME RONALD E. KAYLOR				14. MOTHER'S MAIDEN NAME ANITA MAE STROSNIDER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>770</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Glycoblastoses fetalis in sensitivity in mother</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>9-14 1960 9-14 1960</i>		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, and that death occurred at 5:20 from the causes and on the date stated above.								
22a. SIGNATURE <i>W. Royce Hodges</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) DR. ROYCE HODGES		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-16-60		23c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <i>None</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 13 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

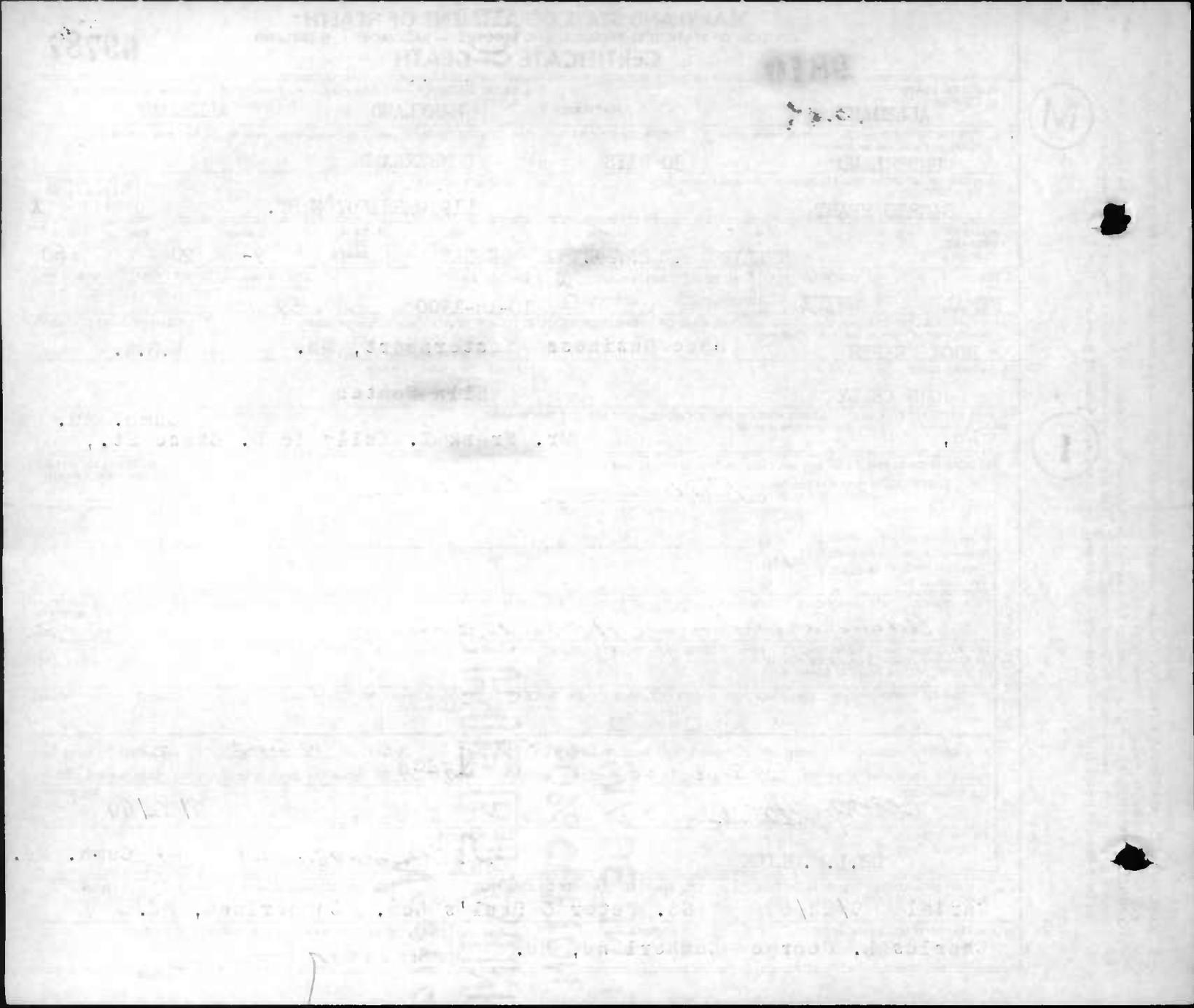
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09787

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 30 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART		d. STREET ADDRESS 419 WASHINGTON ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First NELLIE	Middle BERNADETTE	Last KELLY
4. DATE OF DEATH	Month 9-	Day 20	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1900
9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS. Hours 59	12. IF UNDER 24 HRS. Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10b. KIND OF BUSINESS OR INDUSTRY Shoe Business	
11. BIRTHPLACE (State or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KELLY		14. MOTHER'S MAIDEN NAME Ella Footen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Frank T. Kelly 16 N. Chase St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Embolism		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 465X		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) AdenoCarcinoma of the left Lung		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 Aug 1960 to 19 Sept 1960 , that (I) (we) last saw the deceased alive on 19 Sept 1960 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 9/21/60	
22a. SIGNATURE L.M. Glick		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. L. M. GLICK		22d. ADDRESS 126 N. Smallwood St. Cumb. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/60	
23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul's Cem. Cumberland, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR DATE SEP 23 '60		25b. REGISTRAR'S SIGNATURE S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09788

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zihlman		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hope Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE		First ELLEN	Middle LANCASTER
4. DATE OF DEATH Last 9	Month 2	Day 19	Year 60
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1870
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Borden Mines		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Skidmore		14. MOTHER'S MAIDEN NAME Susan Weitzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Lancaster Address Frostburg Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Fracture RT Humerus		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.0 (b) DUE TO (c)		10 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. A Fall in Room		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour Aug 23 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home	
20f. (City or town) Zihlman Allegany Md		(County) Zihlman Allegany	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE WOM Lane	DATE SIGNED Sept 3 1960		
EXAMINER'S NAME (Type) WOM Lane ast	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Porter Cemetery Hafer Funeral Home	22d. LOCATION (City, town, or county) (State) Eckhart Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bullock & Montague	ADDRESS 23 East Main, Frostburg	24a. REC'D BY REGISTRAR SEP 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Lewis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

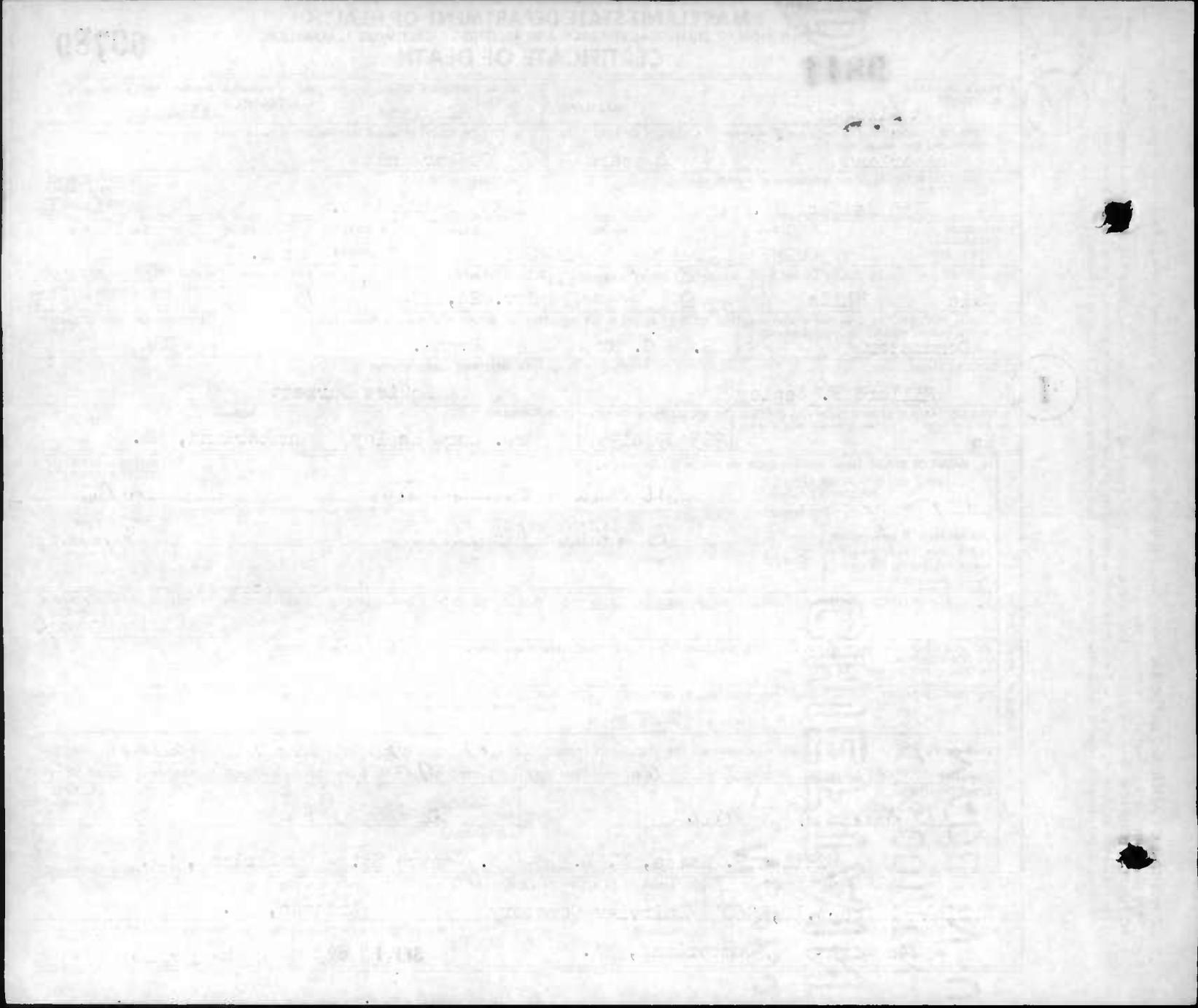
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

69789

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 355 Bedford St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) DORSEY DALTON LEPLEY		4. DATE OF DEATH Month Sept. 7 Day 19 Year 60	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR	11. BIRTHPLACE (State or foreign country) Penna.
13. FATHER'S NAME Millard F. Lepley		14. MOTHER'S MAIDEN NAME Louise Burkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705 09 4195	17. INFORMANT Mrs. Cora Lepley
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary & Circumstances		INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prostate Cancer		DUE TO 3 years	
DUE TO Urinary & Circumstances			
DUE TO Prostate Cancer			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-12 , 19 60 , to 9-7 , 19 60 that (I) (we) last saw the deceased alive on 8-2 , 19 60 , and that death occurred at 715 M , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE William P. James		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) William P. James, M. D.		22d. ADDRESS N. Centre St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 10, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	23d. LOCATION (City, town, or county) Artemas, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR SEP 13 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Thorne



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

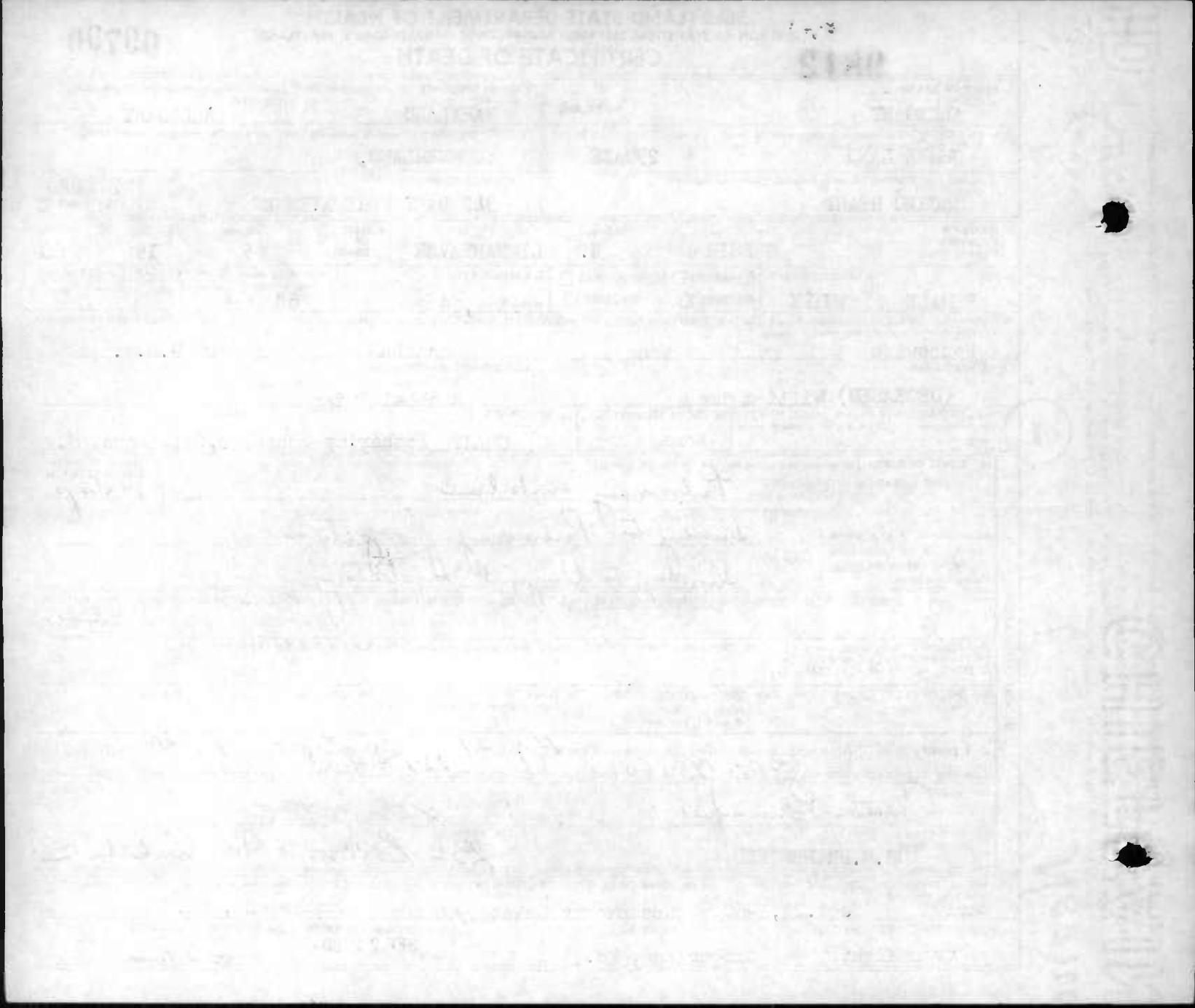
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09790

9812

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 29 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				d. STREET ADDRESS 342 BALTIMORE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First BESSIE	Middle E.	Last LINNAWEAVER	4. DATE OF DEATH Month 9	Day 19	Year 19 60
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (DECEASED) William Tmes				14. MOTHER'S MAIDEN NAME Rachael Twigg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT CHART Katherine Scheeler, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism INTERVAL BETWEEN ONSET AND DEATH 10 days.							
633 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary to Pulmonary Congestion							
(c) Secondary to Vaginal Hemorrhage							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 21 1960 to Sept. 19 1960 that (I) (we) last saw the deceased alive on Sept. 19 1960 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Carlton Brinsfield		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. C. BRINSFIELD		22d. ADDRESS 232 Bateman An Embankment					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '60		25b. REGISTRAR'S SIGNATURE Charles S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>417½ N. Centre St.</i>		d. STREET ADDRESS <i>417½ N. Centre St. I</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Agnes</i>	Middle <i>Williams</i>	Last <i>Lottig</i>
4. DATE OF DEATH <i>Sept. 25</i>	Month <i>Sept.</i>	Day <i>25</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 17. 1875</i>
9. AGE (In years last birthday) <i>85</i>	10. IF UNDER 1 YEAR Months <i>85</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Frostburg, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Thomas J. Lottig</i>	14. MOTHER'S MAIDEN NAME <i>Ellen Armstrong Williams</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Miss. Anna E. Lottig, Cumberland, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>15 IX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Since 2-2-60</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2-2-60</i> to <i>9-25-60</i> that I last saw the deceased alive on <i>6-17-60</i> , and that death occurred at <i>10:20 a.m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. X. Williams M.D.</i>	ADDRESS (Street, city or town, state) <i>Cumberland, Md.</i>		
POLICE REPORT NO. <i>92760</i>	DATE SIGNED <i>92760</i>		
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 28, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill Mausoleum</i>	22d. LOCATION (City, town, or county) (State) <i>Comberland Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Inc.</i>	ADDRESS <i>Cumberland, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>SEP 29 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

M

WITNESSED

BY

AT

TIME

DATE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

MATERIAL

CLOTHING

SHIRT

PANTS

JACKET

VEST

HAT

SHIRT

PANTS

JACKET

VEST

HAT

SHIRT

PANTS

JACKET

VEST

HAT

E M A R G E
D E A T HNAME OF DECEASED
MATERIALNAME OF SURGEON OR PHYSICIAN
MATERIALNAME OF FUNERAL DIRECTOR
MATERIALNAME OF DECEASED
MATERIALNAME OF SURGEON OR PHYSICIAN
MATERIALNAME OF FUNERAL DIRECTOR
MATERIAL

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										09792							
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 1 DAY					b. COUNTY HAMPSHIRE							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MAXINE		Middle A.		Last MC KEE		4. DATE OF DEATH SEPTEMBER 23		Month	Day	Year					
S. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 29, 1936		9. AGE (In years 24 months birthday) yrs. Months Days Hours Min.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) WEST VIRGINIA					12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME JAMES W. MC KEE					14. MOTHER'S MAIDEN NAME BRENT L. HARDY												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT MEMORIAL HOSPITAL					Address CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Dise (c) Cerebral										Congestive Heart Failure Bedridden Pneumonia Birth					INTERVAL BETWEEN ONSET AND DEATH 24 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour o. m. p. m.		Month 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from Aug 27, 1959 to Sept 23, 1960 , that (I) (we) last saw the deceased alive on Sept 23, 1960 and that death occurred at 7:45 PM from the causes and on the date stated above.																	
22a. SIGNATURE 					M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/25/60												
22c. PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT					22d. ADDRESS 133 Valley, Cumberland, Md												
23a. BURIAL, CREMATION, REBURN (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)											
BURIAL		SEPT. 27, 1960		CAMP HILL CEM.		PAW PAW, W. Va.											
24. FUNERAL DIRECTOR'S SIGNATURE PARKS-JORDAN, BERKELEY SPGS.					25a. REC'D BY REGISTRAR DATE SEP 30 '60					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09793

Reg. Dist. No.

9845

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cresaptown,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D. O. A. Memorial Hosp.				d. STREET ADDRESS Along Rt. # 220				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Emory	Middle Melvin	Last McKenzie	4. DATE OF DEATH Sept. 20, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 8, 1900	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weighmaster		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) Cresaptown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George J. McKenzie				14. MOTHER'S MAIDEN NAME Mary Hershberger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-07-0213		17. INFORMANT Mrs. Elizabeth McKenzie Cresaptown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Gangrenous Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Gangrenous Artery Disease</i> 525 (c) DUE TO <i>-</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Cumberland Alleg. Md.</i>		
21. I certify that I attended the deceased from 7/3/59, 19, to 9/22/60, 19, that I last saw the deceased alive on 7/3/60, 19, and that death occurred at 7:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., Cumberland, Md. DATE SIGNED 9/22/60								
ACTUAL SIGNATURE <i>Richard J. Williams M.D.</i>								
PHYSICIAN'S NAME (Type) Richard J. Williams M.D. Cumberland, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/60		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles L. George Cumberland, Md.								
24a. REC'D BY REGISTRAR DATE SEP 23 '60					24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

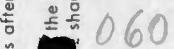
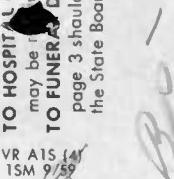
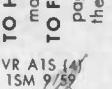
VI. BROMITAE—HYDRANGEA—THYMELAEAE—SAXIFRAGE—CRASSULACEAE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, pages 1 and 3 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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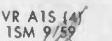




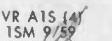
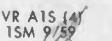






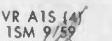




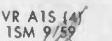


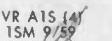








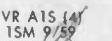



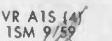






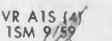




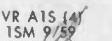










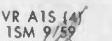
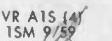















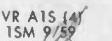










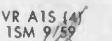
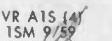


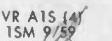


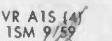


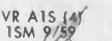
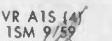


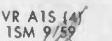


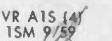











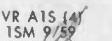
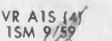
























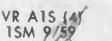










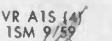


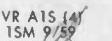












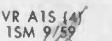










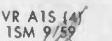










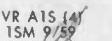


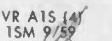






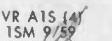


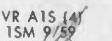




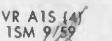






















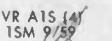










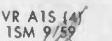











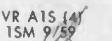




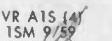




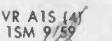




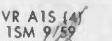

















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MOULTRIE, GA 30066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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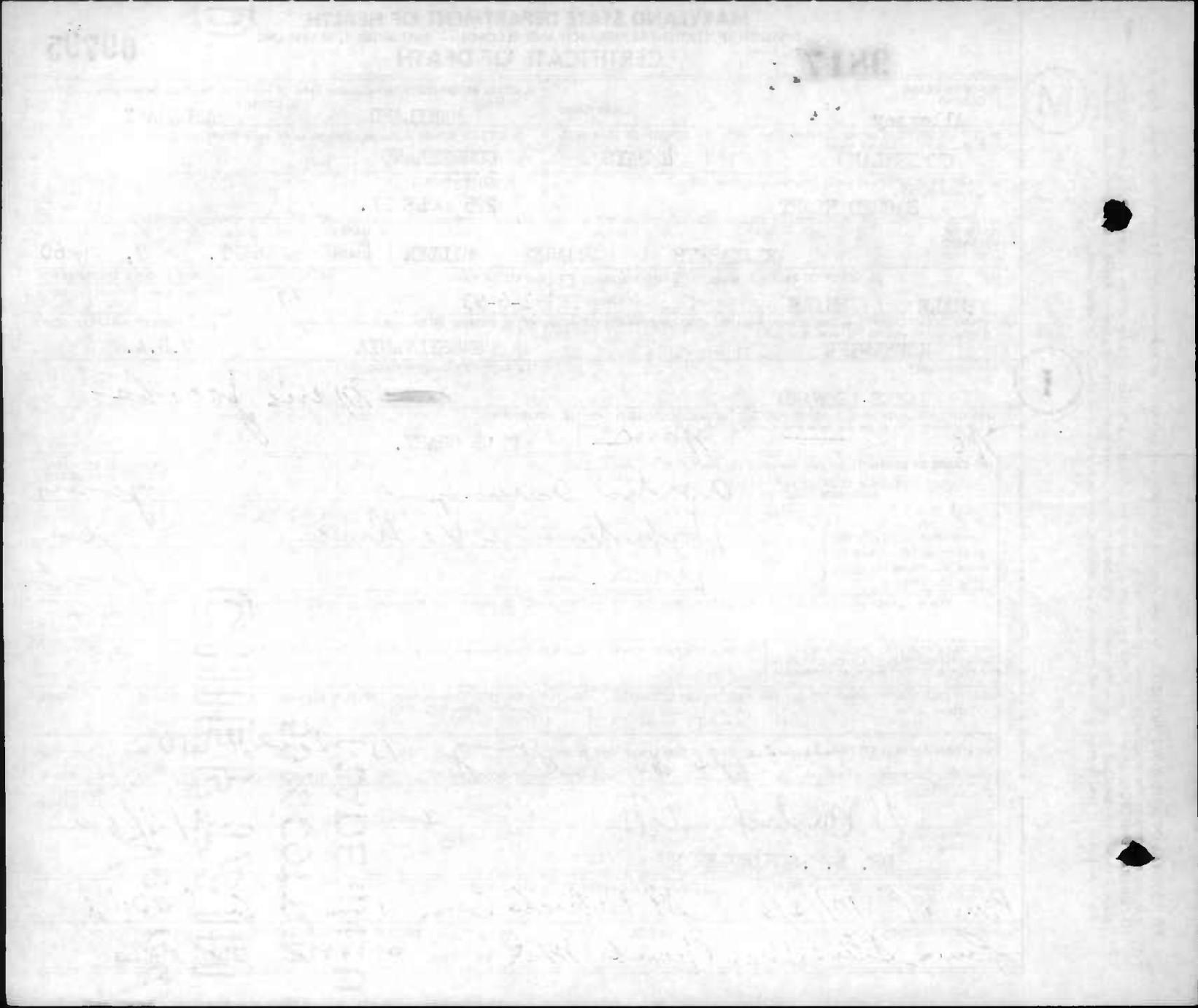
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09795

9817

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 225 COLE ST.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle MARGARET	Last MILLER	4. DATE OF DEATH 1-6-93	Month SEPT.	Day 9,	Year 1960
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-93		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES LEONARD				14. MOTHER'S MAIDEN NAME JACOB <i>Marie Jacobs</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT PT'S CHART.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C.V. Disease DUE TO (c) menia								
INTERVAL BETWEEN ONSET AND DEATH years								
(b) years								
(c) months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to Sept 9, 1960 , that (I) (we) last saw the deceased alive on July 1960 , and that death occurred at M. from the causes and on the date stated above.								
22a. SIGNATURE B.M. Schindler				22b. DATE SIGNED 9/9/60				
22c. PHYSICIAN'S NAME (Type) DR. B.M. SCHINDLER MD				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/60		23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick Cem.		23d. LOCATION (City, town, or county) (State) Cumberland 238		
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR DATE SEP 14 '60				
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09796

9836

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCooole		c. LENGTH OF STAY IN 1b 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCooole	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John		First William	Middle Moore	4. DATE OF DEATH Sept. 25	Month Day Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 22, 1882	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alonzo Moore		14. MOTHER'S MAIDEN NAME Sadie Murphy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs John W. Moore, McCooole, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Degeneration Not specified as Rheumatic		INTERVAL BETWEEN ONSET AND DEATH 5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 11 1955 to Sept 25 1960, that (I) (we) last saw the deceased alive on Sept 24 1960, and that death occurred at 12 M, from the causes and on the date stated above.					
22a. SIGNATURE Paul R. Wilson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 26, 1960	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.		22d. ADDRESS Piedmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/60		23c. NAME OF CEMETERY OR CREMATORIALight Cemetery	
				23d. LOCATION (City, town, or county) (State) Cross, Mineral ct., W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE El. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Traus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
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 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9857

CERTIFICATE OF DEATH

09797

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 292 National Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Francis	Middle Alan	Last Gordon Murray
4. DATE OF DEATH	Month September	Day 11	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1876
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician & Surgeon	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Mosley Murray	14. MOTHER'S MAIDEN NAME Mabel Mills		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. WW 1	17. INFORMANT Mrs. Gertrude Murray	292 National Highway La Vale, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with right hemiplegia.			
INTERVAL BETWEEN ONSET AND DEATH approx. 4 da.			
DUE TO 422			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease. 15 years			
DUE TO (c) Generalized arteriosclerosis. ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 February 1959 to 11 September 1960 that (I) (we) last saw the deceased alive on 11 Sept. 1960 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>W. Alfred VanOrmer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. Alfred VanOrmer M.D.		22d. ADDRESS 122 So. Centre St., Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 12, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Restlawn Burial Park		23d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hafner Funeral Service, Cumberland, Md.</i>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE SEP 14 '60	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

HTA3140 INSTITUTE OF APPLIED SCIENCES
TECHNICAL COLLEGE, KARACHI
1990-91

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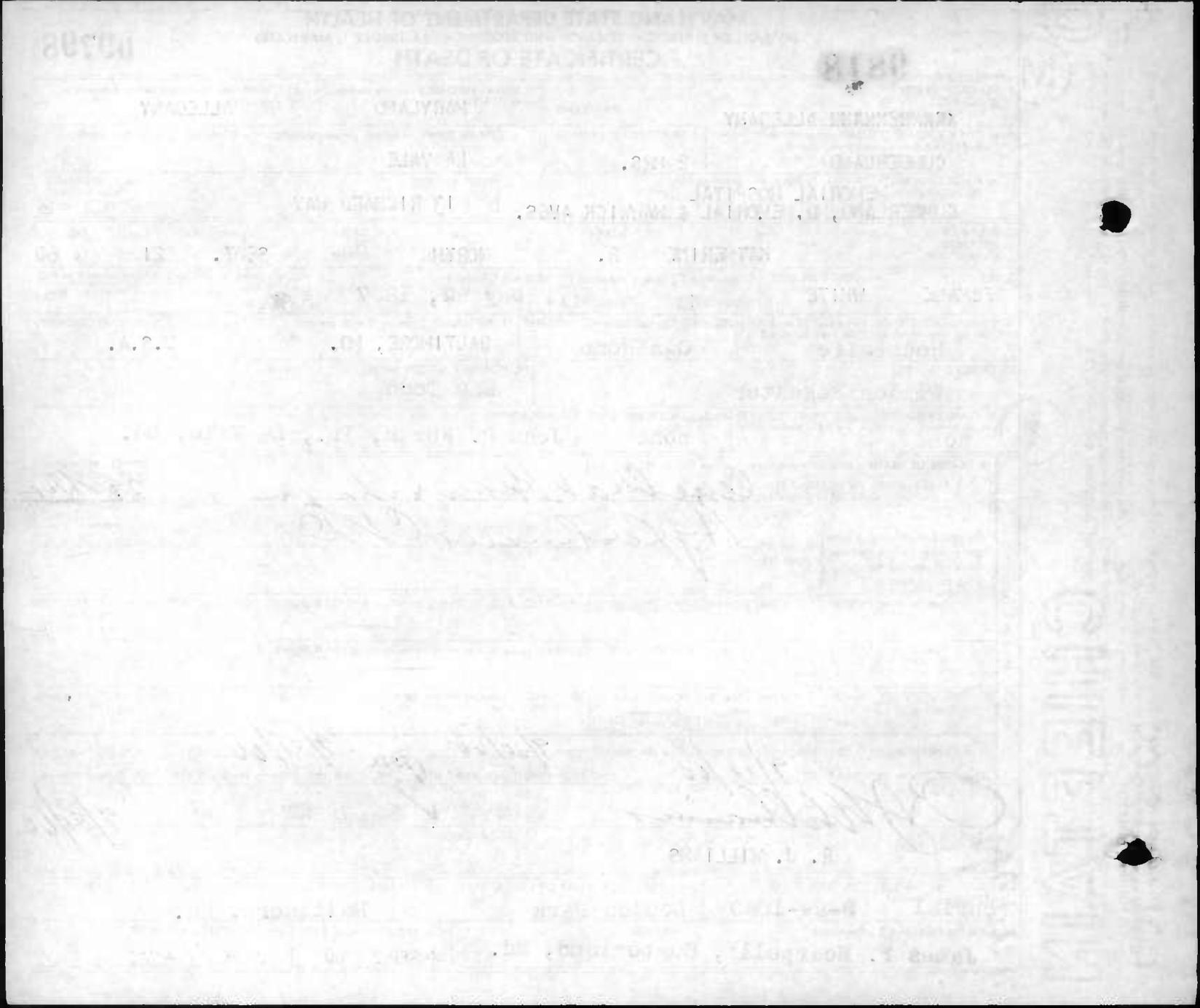
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09798

M		9848		1	
1. PLACE OF DEATH a. COUNTY X RUMBERK AND ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 HRS.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LA VALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL CUMBERLAND, MD. MEMORIAL & WARWICK AVE.		e. STREET ADDRESS 13 RICHARD WAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE R.		First	Middle	Last	4. DATE OF DEATH Month SEPT. Day 21 Year 19 60
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1907		9. AGE (In years last birthday) 53XX yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME Wilson Regester		14. MOTHER'S MAIDEN NAME May Todd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address John R. North, Jr., La Vale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 20 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X					
(b) HyperTensive CVD —					
(c) —					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from 9/20/60 to 9/21/60 , 19, that (I) (we) last saw the deceased alive on 9/20/60 , and that death occurred at 635a , M, from the causes and on the date stated above.					
22a. SIGNATURE R. J. Williams		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/21/60	
22c. PHYSICIAN'S NAME (Type) R. J. WILLIAMS		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-1960		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
				25b. REGISTRAR'S SIGNATURE John S. Harlan	



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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09799

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 10 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Stella	Middle M.	Last Odggers
4. DATE OF DEATH	Month September	Day 22nd	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25th, 1885
9. AGE (In years last birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk	11. KIND OF BUSINESS OR INDUSTRY Dept. Store	12. BIRTHPLACE (State or foreign country) Maryland
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME Mary Jane Edwards		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-01-0343	17. INFORMANT Harry Odgers,	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Cardiac Failure (RT Side) 24 hrs Cardiovascular disease years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 60 , to 9/22 , 19 60 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 9/22 , 19 60 , and that death occurred at 3 AM , from the causes and on the date stated above.	22. SIGNATURE John B. Davis		
22c. PHYSICIAN'S NAME (Type) John B. Davis	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/23/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-24-60	23c. NAME OF CEMETERY OR CREMATORIAL F' bg. Memorial Park	23d. LOCATION (City, town, or county) (State) Frostburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. Roberts	ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE SEP 26 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

M

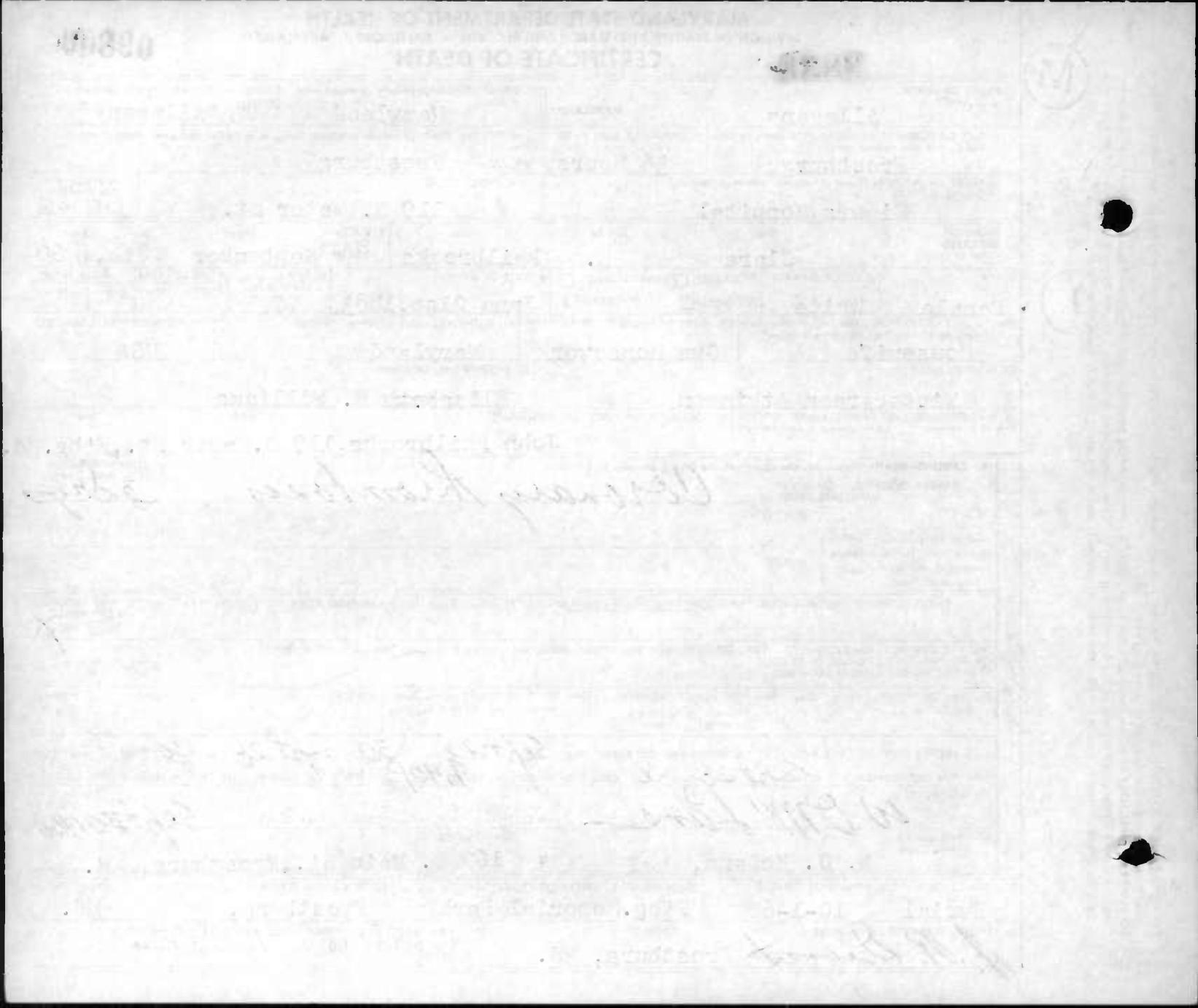
7

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

69800

928

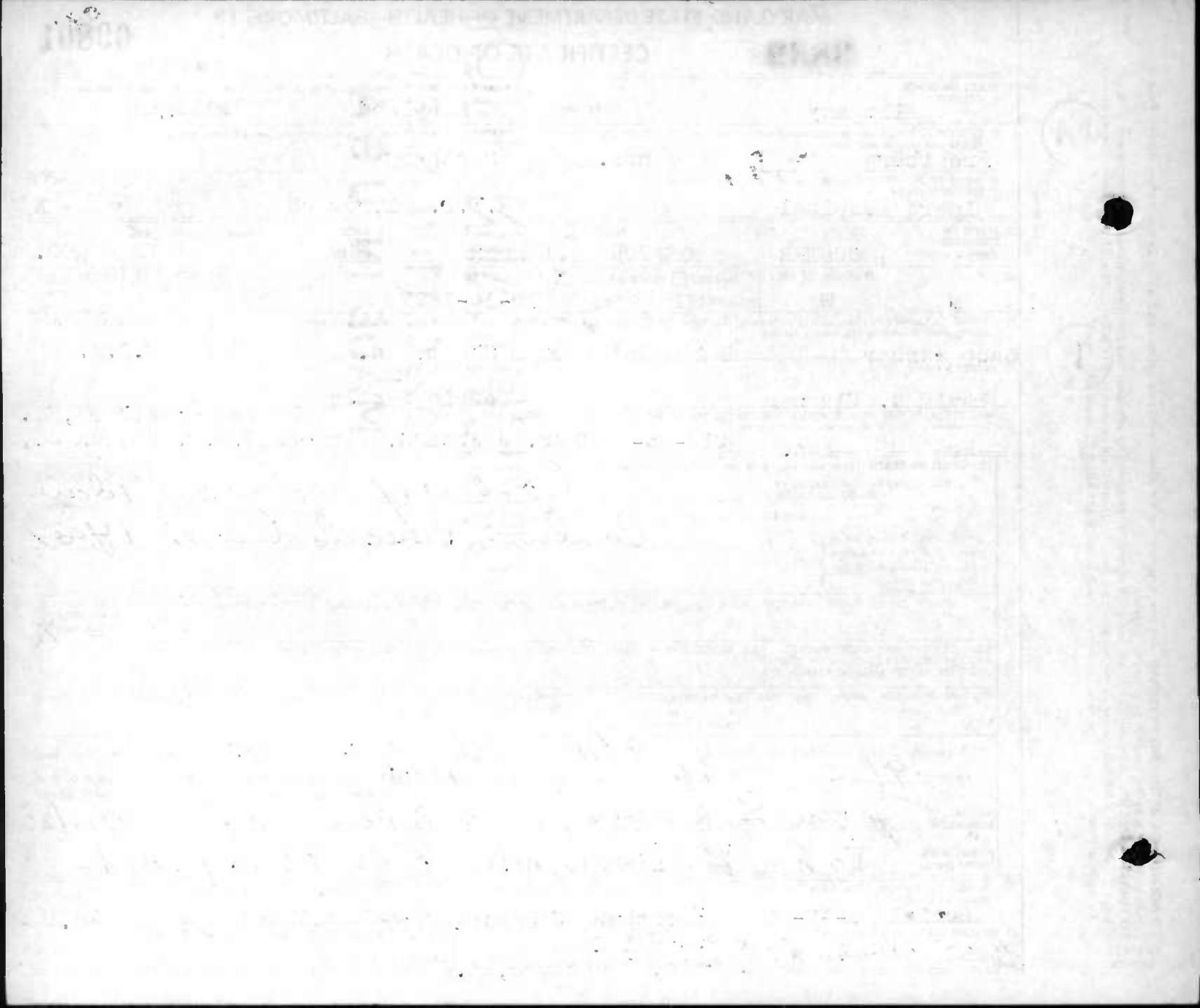
1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		Allegany	
Allegany				c. LENGTH OF STAY IN 1b		22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frostburg		36 Hours		Frostburg		d. STREET ADDRESS		119 S. Water St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Miners Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Clara				E.		Philbrooks		September 28th, 1960			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 21st, 1883		77 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own housework		Maryland				USA			
13. FATHER'S NAME											
Wintergreen Atkinson											
14. MOTHER'S MAIDEN NAME											
Elizabeth E. Williams											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(If yes, give war or dates of service)						John Philbrooks, 119 S. Water St., F'bg. M					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
420-1 DUE TO Coronary thrombosis 3 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from Sept 23, 1930, to Sept 28, 1930, that (I) (we) last saw the deceased alive on Sept 28, 1930, and that death occurred at 1145 P.M. from the causes and on the date stated above.											
22a. SIGNATURE		W. O. McLane		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		W. O. McLane,		II		22d. ADDRESS		Sept 30, 1960			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county)		(State)			
Burial		10-1-60		F'bg. Memorial Park		Frostburg,		Md.			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. P. Deurst		Frostburg, Md.		OCT 3 '60		Arthur L. Haas					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filled by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 09801		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH o. COUNTY Allegany MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 6 hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			d. STREET ADDRESS R.F.D. #1, Box 38					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CUSTER		First SEATON		Middle PLUMMER		Last		4. DATE OF DEATH		Month 9	Day 15	Year 1960.		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-1897		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop worker			10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad			11. BIRTHPLACE (State or foreign country) Shaft, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David H. Plummer						14. MOTHER'S MAIDEN NAME Carrie Seaton								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			INFORMANT Mr. Ausbee S. Plummer, R.F.D. #1, Box 38,			Address Frostburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)												Coronary occlusion 1 day		
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c)												Cardio- Vascular disease 1 year		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 9/11, 1960, to 9/15, 1960, that I last saw the deceased alive on 9/15, 1960, and that death occurred at 11 AM, from the causes and on the date stated above.												ADDRESS (Street, city or town, state) John B. Davis, M.D. 2 Broadway Frostburg, Md. DATE SIGNED 9/16/60		
ACTUAL SIGNATURE John B. Davis, M.D. John B. Davis, M.D. Frostburg, Md.														
PHYSICIAN'S NAME (Type)			22b. DATE THEREOF 9-17-60			22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park			22d. LOCATION (City, town, or county) Frostburg			(State) Md.		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial			22f. ADDRESS Hafer Funeral Home			240. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesano			23. E. Main, Frostburg, Md.			DATE SEP 19 '60								



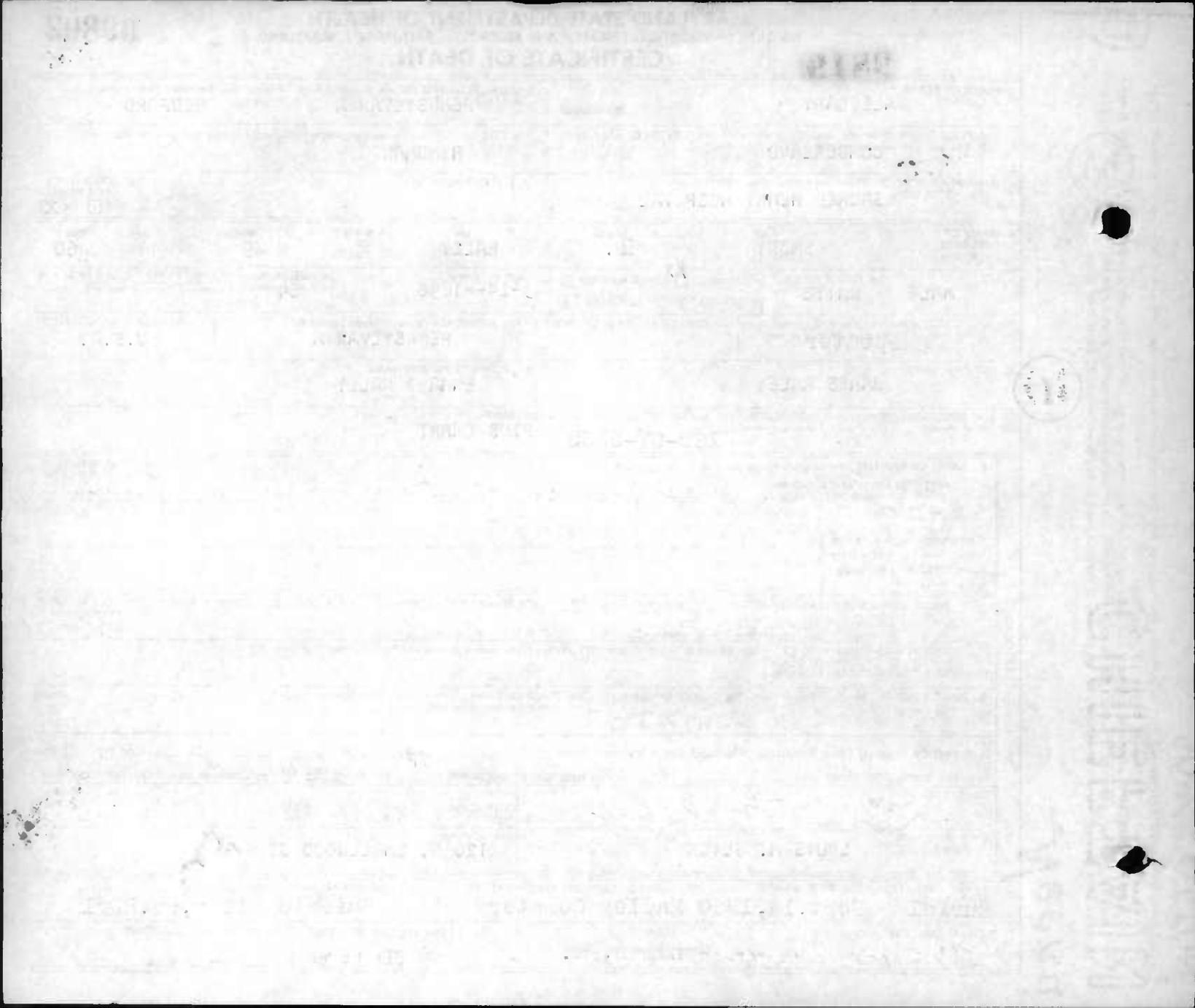
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

69802

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUMBERLAND		c. LENGTH OF STAY IN 1b 16		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN		d. STREET ADDRESS 75 X-3		
3. NAME OF DECEASED (Type or print) First EMORY		Middle E.		Last RALEY		4. DATE OF DEATH Month 9	Day 11	Year 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		
13. FATHER'S NAME JAMES RALEY			14. MOTHER'S MAIDEN NAME EMMA ? RALEY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT PTI'S CHART		
Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas INTERVAL BETWEEN ONSET AND DEATH undetermined								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) obstructive Jaundice 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 , 19 60 , to 7/10 , 19 60 , that (I) (we) last saw the deceased alive on 7/9 , 19 60 , and that death occurred at 7/10 , 19 60 , M, from the causes and on the date stated above.								
22a. SIGNATURE Louis M. Glick					22b. DATE SIGNED Sept. 14, 1960			
22c. PHYSICIAN'S NAME (Type) LOUIS M. GLICK					22d. ADDRESS 126 N. SMALLWOOD STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Madley Cemetery		23d. LOCATION (City, town, or county) (State) Buffalo Mills, Pa. RD#1		
24. FUNERAL DIRECTOR'S SIGNATURE Hyndman, Pa.					ADDRESS		25a. REC'D BY REGISTRAR Hyndman, Pa.	25b. REGISTRAR'S SIGNATURE Charles S. Thomas
					DATE SEP 15 '60			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09803

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 317 McMullen Highway		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) James C. Reed		First	Middle	Last	4. DATE OF DEATH September 7 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1911	9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John L. Reed				14. MOTHER'S MAIDEN NAME Mary Walsh				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 244-07-6765		17. INFORMANT Regina Felton Reed 317 McMullen H'way Cumb. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH SUDDEN DUE TO (b) CORONARY SCLEROSIS ----- DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . Benedict Skitarelic ACTUAL SIGNATURE M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED SEPT. 7, 1960 EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc.		ADDRESS 117 Fred. St. Cumb. Md.	24a. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Price			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09804

9821

M

PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE Maryland

b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

5/31/60

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Allegany County Infirmary

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. STREET ADDRESS

Rt. 3, Union Grove Rd.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

First Barbara Middle Catherine Last Rittenour

4. DATE
OF
DEATH

Month September Day 18, Year 1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

5/5/1877

9. AGE (in years
last birthday)

83

yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Ownhome

11. BIRTHPLACE (State or foreign country)

Bergton, Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Perry Whitmer

14. MOTHER'S MAIDEN NAME

Barbara C. DeLawder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

P.O. Box 599,

Address Cumberland, Md.

Allegany County Infirmary Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)592X DUE TO
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost. (b)DUE TO
(c)

Chronic Myocardial Degeneration ?

Cerebral arteriosclerosis ?

Chronic Nephritis ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Senile deterioration

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5/31/60 19 to 9/18/60 19, that (I) (we) last
saw the deceased alive on 9/17/60 19, and that death occurred M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Dr. James E. McLean

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
9/19/60

22d. ADDRESS

49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial23b. DATE THEREOF
9-20-6023c. NAME OF CEMETERY OR CREMATORIUM
Lost City Cem.

23d. LOCATION (City, town, or county) (State)

Lost City, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE

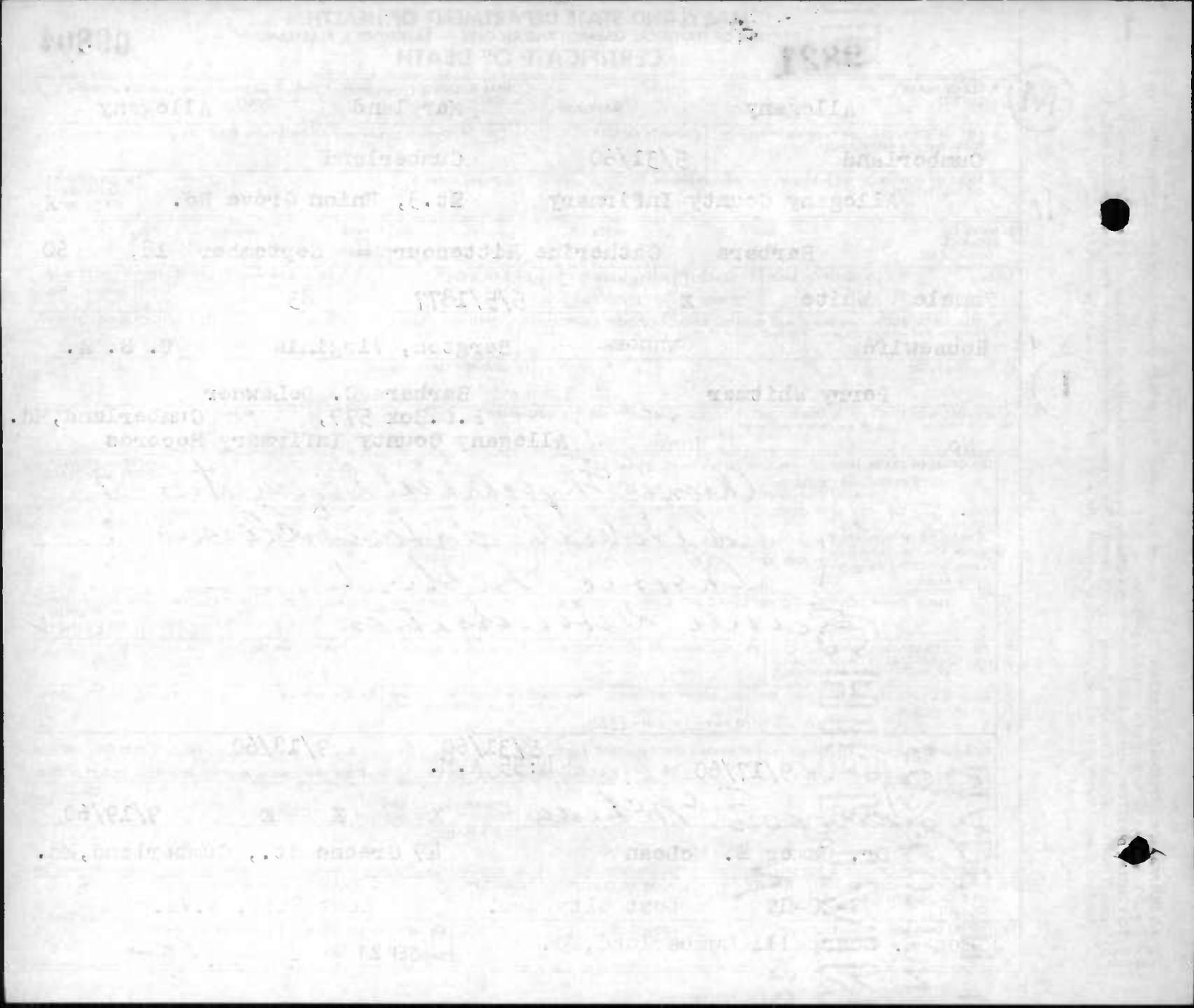
ADDRESS
James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR

DATE SEP 21 '60

25b. REGISTRAR'S SIGNATURE

Clyburn S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09805

1. PLACE OF DEATH a. COUNTY		3822 ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) CRIMONIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 510 CITY VIEW TERRACE			
3. NAME OF DECEASED (Type or print)		First FRANK	Middle E.	Last ROBINSON	4. DATE OF DEATH SEPTEMBER 27 1960	Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 1, 1900	
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Tire Plant		11. BIRTHPLACE (State or foreign country) CANOE, PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES H. ROBINSON		14. MOTHER'S MAIDEN NAME SARAH I. BURGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No		17. INFORMANT 217-10-4910 MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		190.9		Maligant Melanoma		INTERVAL BETWEEN ONSET AND DEATH 30 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Cumberland Allegy Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/26/60 to 2/27/61, that (I) (we) last saw the deceased alive on 19 _____, and that death occurred at 10:15 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>R. Williams</i>		22b. DATE SIGNED		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-30-60		23c. NAME OF CEMETERY OR CREMATORIAL Canoe Creek Cem.		23d. LOCATION (City, town, or county) Canoe Creek, Pa. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

WADDELL

CHURCH

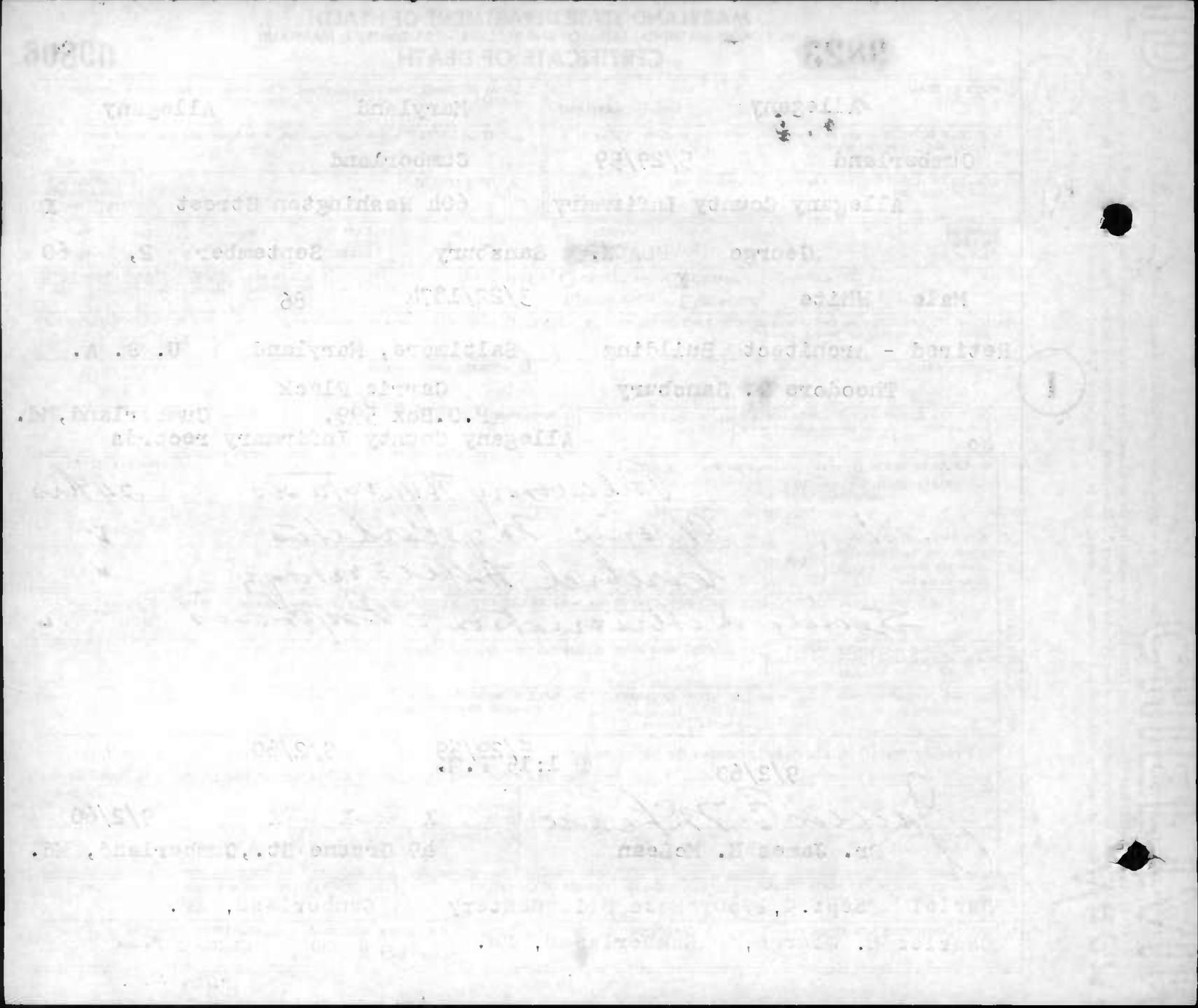
YERGEN

CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5/29/59											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland											
3. NAME OF DECEASED (Type or print) First George Middle FLACK. Last Sansbury				4. DATE OF DEATH September 2, 1960 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/1874		9. AGE (in years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Architect				10b. KIND OF BUSINESS OR INDUSTRY Building				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Theodore T. Sansbury				14. MOTHER'S MAIDEN NAME Carrie Flack											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT P.O.Box 599, Allegany County Infirmary records				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												24 hrs			
(b) DUE TO <i>Chronic Myocarditis</i>												✓			
(c) DUE TO <i>Cerebral Hemorrhage</i>												✓			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Senile Deterioration & Psychoses</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5/29/59 19 to 9/2/60 19, that (I) (we) last saw the deceased alive on 9/2/60 19, and that death occurred at M, from the causes and on the date stated above.												22b. DATE SIGNED 9/2/60			
22a. SIGNATURE <i>James E. McLean</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 4, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery				23d. LOCATION (City, town, or county) Cumberland, Md. (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,				ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR Date SEP 6 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>					



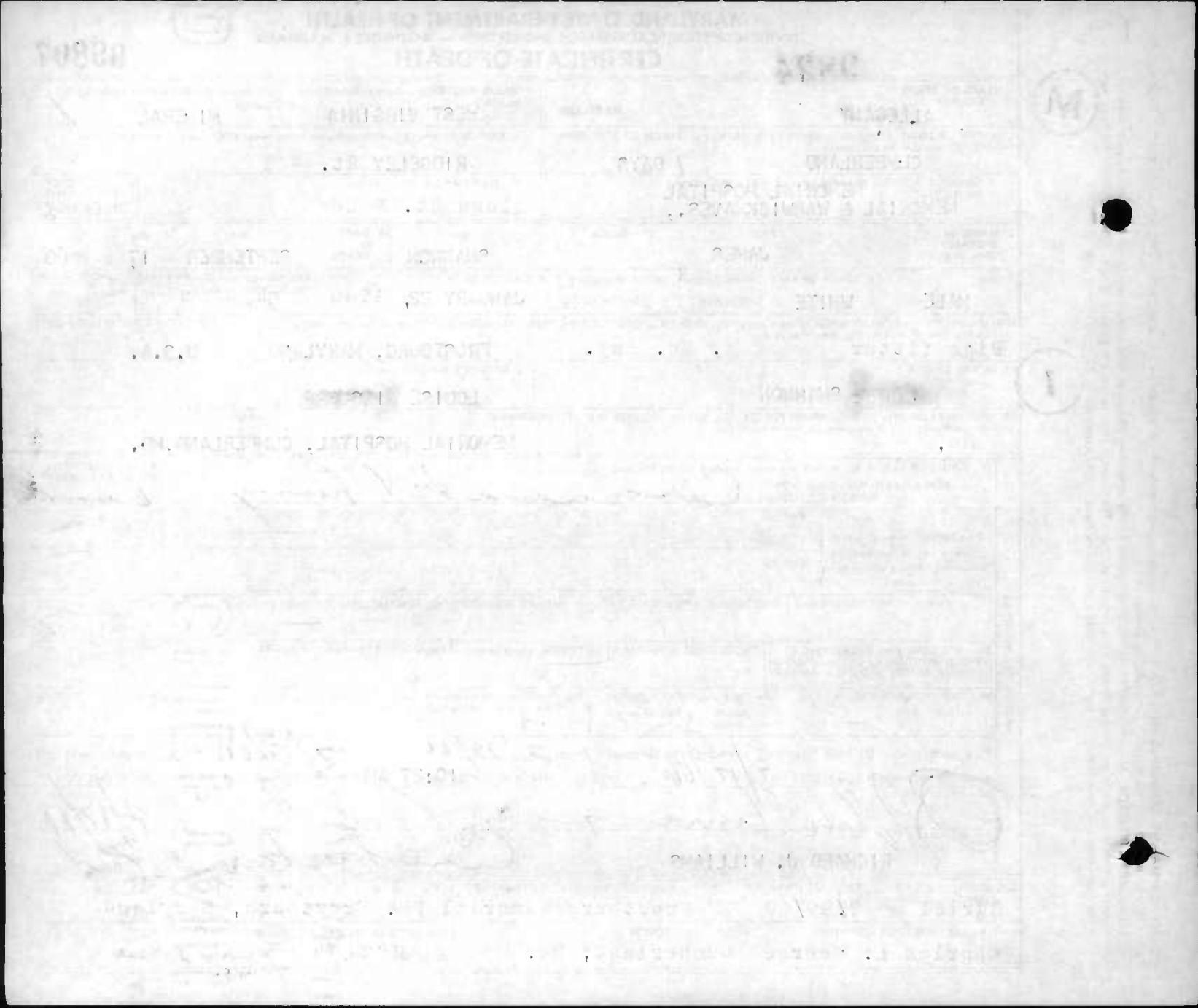
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9824		09807																											
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA					3. LENGTH OF STAY IN lb MARYLAND																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY Rt. # 1					d. STREET ADDRESS Along Rt. # 28																			
d. NAME OF HOSPITAL (If in hospital, give hospital address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
3. NAME OF DECEASED (Type or print)		First JAMES		Middle		Last SHANNON		4. DATE OF DEATH		Month SEPTEMBER		Day 17		Year 1960															
S. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 22, 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54		IF UNDER 24 HRS. Days 54		Hours 54															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter					10b. KIND OF BUSINESS OR INDUSTRY W. Md. Rwy.					11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME Edgar SHANNON					14. MOTHER'S MAIDEN NAME LOUISE Roberts																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,					16. SOCIAL SECURITY NO.					17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															INTERVAL BETWEEN ONSET AND DEATH 6 weeks														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)															Carolina B. L. Henry														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) injury																								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home					20f. (City or town) (County) (State) Frostburg (Washington) (Md.)														
21. I certify that (I) (this hospital) attended the deceased from 2/15/60 19 to 2/17/60 19, that (I) (we) lost sight of the deceased alive on 2/17/60 , and that death occurred 10:27 AM from the causes and on the date stated above.															22b. DATE SIGNED 2/17/60														
22a. SIGNATURE R. Williams															22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Richard J. Williams														
22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS					23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 9/20/60					23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Pk.					23d. LOCATION (City, town, or county) (State) Frostburg, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George															ADDRESS Cumberland, Md.					25a. REC'D BY REGISTRAR DATE SEP 21 '60					25b. REGISTRAR'S SIGNATURE Charles L. George				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

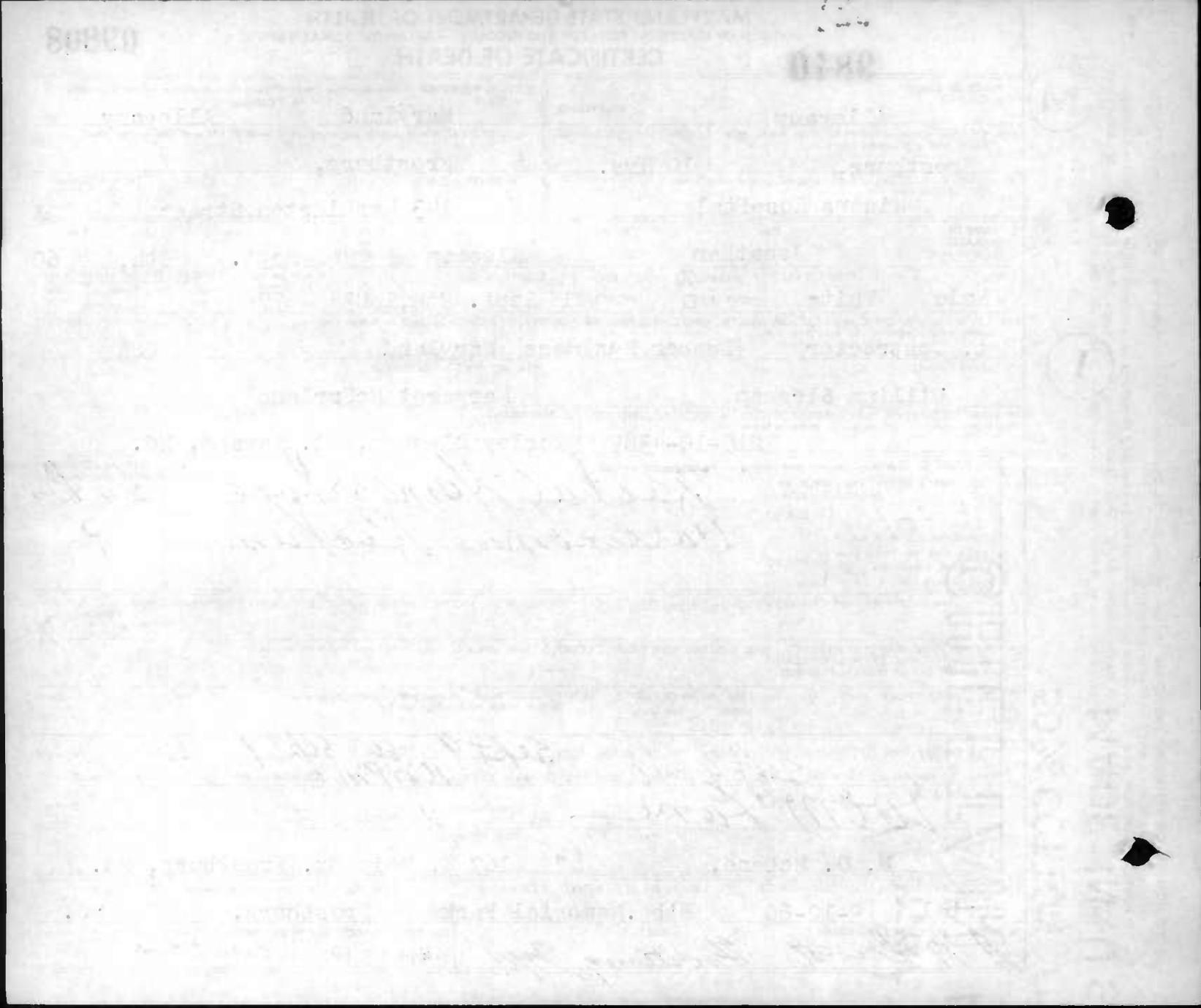
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09808

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 10 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jonathan	Middle Sleeman	Last Sept. 9th, 1960
4. DATE OF DEATH	Month Sept.	Day 9th,	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9th, 1883
9. AGE (In years last birthday) 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contractor	11. KIND OF BUSINESS OR INDUSTRY Lumber Business	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Sleeman	14. MOTHER'S MAIDEN NAME Margaret McFarland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-10-4389	17. INFORMANT Wesley Sleeman, Mt. Savage, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Rectal Hemorrhage 24 hrs Carcinoma Rectum ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 9 1960 to Sept 9 1960 , that (I) (we) last saw the deceased alive on Sept 9 1960 , and that death occurred 10:15 AM from the causes and on the date stated above.			
22a. SIGNATURE W. O. McLane		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) W. O. McLane,		22d. ADDRESS 167 E. Main St., Frostburg, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9-12-60	23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	23d. LOCATION (City, town, or county) (State) Frostburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE SEP 13 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

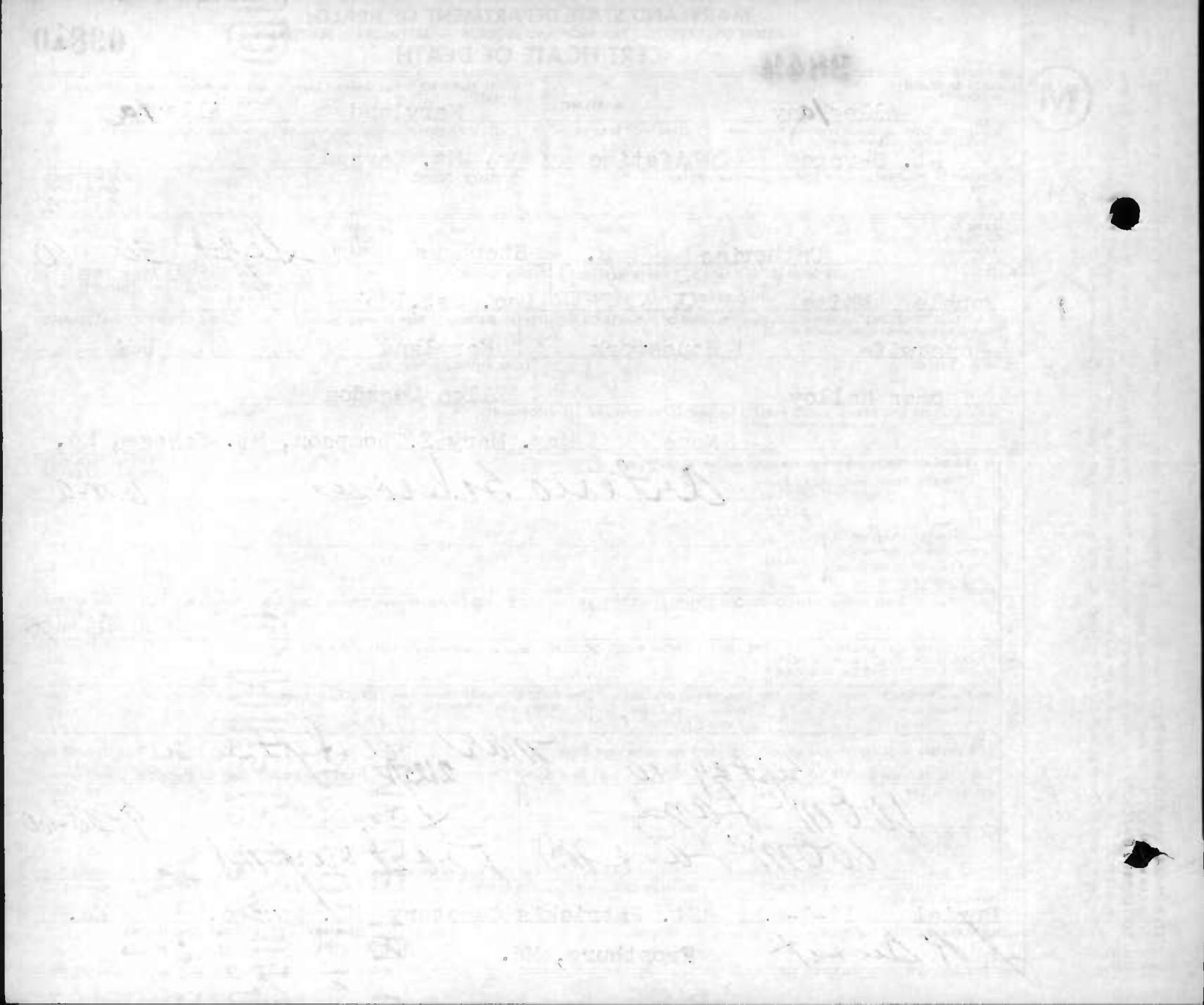
Reg. Dist. No. 09809

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 48 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LOUIS	Middle <i>Peter</i>	Last SOTERAKOS
4. DATE OF DEATH Month Day Year 9 17 19 60	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 24 1880	9. AGE (In years from birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Confectioner	
11. BIRTHPLACE (State or foreign country) Sparta Greece		12. CITIZEN OF WHAT COUNTRY? A. S.A.	
13. FATHER'S NAME Peter Soterakos		14. MOTHER'S MAIDEN NAME (Unknown) Stavroula	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louis Soterakos		Address Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 42a.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) CORONARY SCLEROSIS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED SEPT. 17, 1960	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/60	
22c. NAME OF CEMETERY OR CREMATORIUM Zion Mem. Rek		22d. LOCATION (City, town, or county) Cumberland MD	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc Cumb. MD.		ADDRESS 117 COLUMBIA STREET	
		24a. REC'D BY-REGISTRAR DATE SEP 21 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

100



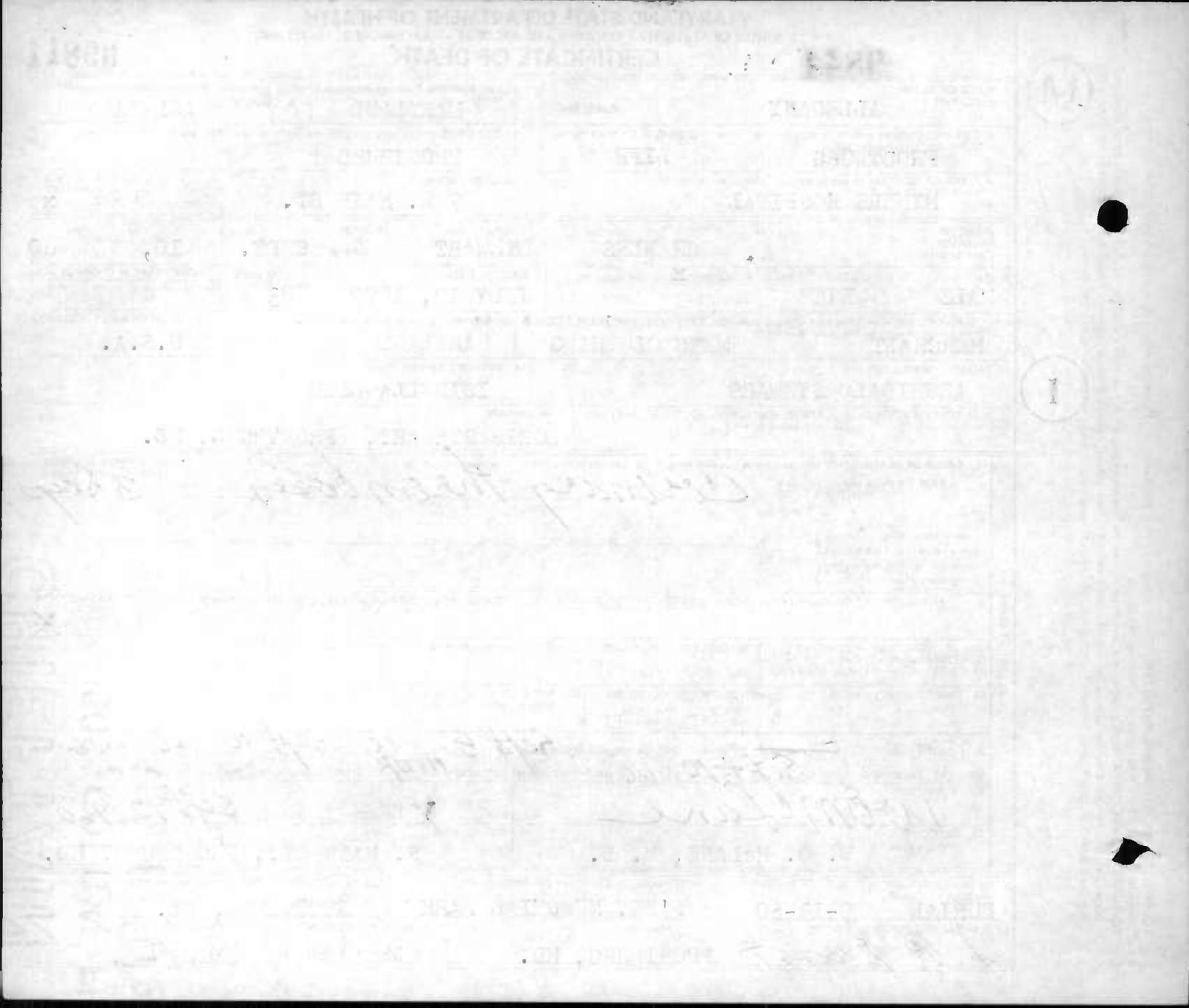
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9841		09811																											
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY ALLEGANY																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG					c. LENGTH OF STAY IN 1b LIFE					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL					d. STREET ADDRESS 7 W. MAIN ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)		First A.	Middle CHARLES	Last STEWART	4. DATE OF DEATH SEPT. 10, 1960		Month Year	Day	Year	5. SEX MALE				6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 12, 1877		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT					10b. KIND OF BUSINESS OR INDUSTRY MENS CLOTHING					11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME ARCHIBALD STEWART					14. MOTHER'S MAIDEN NAME ISABELLA ROBB					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT DORIS STEWART, FROSTBURG, MD.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary thrombosis</i>																													
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____										DUE TO																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY - Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept 8 1960 to Sept 10 1960 , that (I) (we) last saw the deceased alive on Sept 10 1960 and that death occurred at 11:22 P.M. from the causes and on the date stated above.					22a. SIGNATURE <i>W.O. McLane</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <i>Sept 12 1960</i>														
22c. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.					22d. ADDRESS E. MAIN ST., FROSTBURG, MD.					23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF 9-13-60					23c. NAME OF CEMETERY OR CREMATORIAL F'BG. MEMORIAL PARK					23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR'S SIGNATURE <i>J.P. Durst</i>					ADDRESS FROSTBURG, MD.					25a. REC'D BY REGISTRAR DATE SEP 14 '60					25b. REGISTRAR'S SIGNATURE <i>Arthur L. Knapp</i>														



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19812

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or for burial, cremation, or removal.

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1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 78 East Mechanic Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth		First K.	Middle Stott
4. DATE OF DEATH 6/16/21		Last 9	Month 12
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6/16/21		9. AGE (In years from birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Eckhart, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harris		14. MOTHER'S MAIDEN NAME Alice Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Stott, 4813 Calvert Road,		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 422.2 <i>Acute Cardiac Dilitation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Myocardial Insufficiency</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1/2 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>W.O. McLane</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>Sept 12 1960</i>	
EXAMINER'S NAME (Type) <i>W.O. McLane M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-60	22c. NAME OF CEMETERY OR CREMATORIUM Percy Cemetery
22d. LOCATION (City, town, or county) Frostburg		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ba</i>		ADDRESS Hafer Funeral Home 23 East Main, Frostburg, Md.	24a. REC'D BY REGISTRAR DATE SEP 16 '60
		24b. REGISTRAR'S SIGNATURE <i>C. Hafer</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

69813

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

3 Hrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

22 Frostburg

d. STREET ADDRESS

14 Locust Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
H.Middle
MarshallLast
Tippen4. DATE
OF
DEATHMonth
September
Day
16th, 1960
Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

Dec. 19th, 1913

9. AGE (In years
lost birthday)

46 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Disab.-Air Force Emp. Sheet Metal

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry Tippen

14. MOTHER'S MAIDEN NAME

Clara Winebrenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL SECURITY NO.

217-10-1610

17. INFORMANT

Mrs. Bertha W. Tippen, Frostburg, Md.

Address
14 Locust St.,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)443 X
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)

DUE TO

(c)

Altered accident (remedy) 1 day.
Hypertensive Cardio-Vascular
disease 1 year.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 9/14/60 to 9/16/60, that (I) (we) last saw the deceased alive on 9/16/60 and that death occurred at 6 PM, from the causes and on the date stated above.

22a. SIGNATURE

John B. Davis,

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
9/17/6022c. PHYSICIAN'S
NAME (Type)

John B. Davis,

22d. ADDRESS

2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial 9-19-60

23b. DATE THEREOF

St. Michael's Cemetery Frostburg, Md.

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

J.P. Duerst

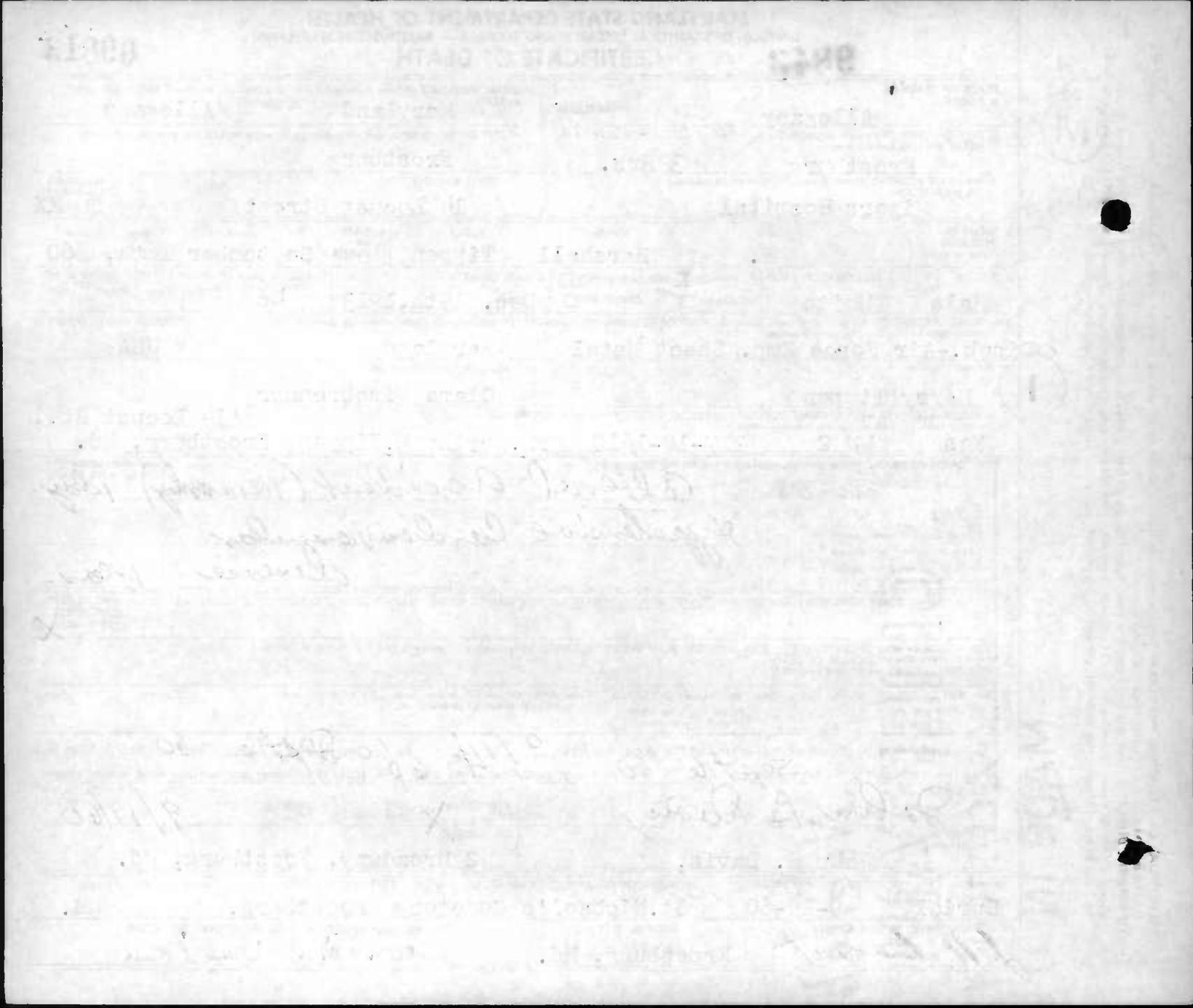
Frostburg, Md.

25a. REC'D BY REGISTRAR

DATE SEP 20 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

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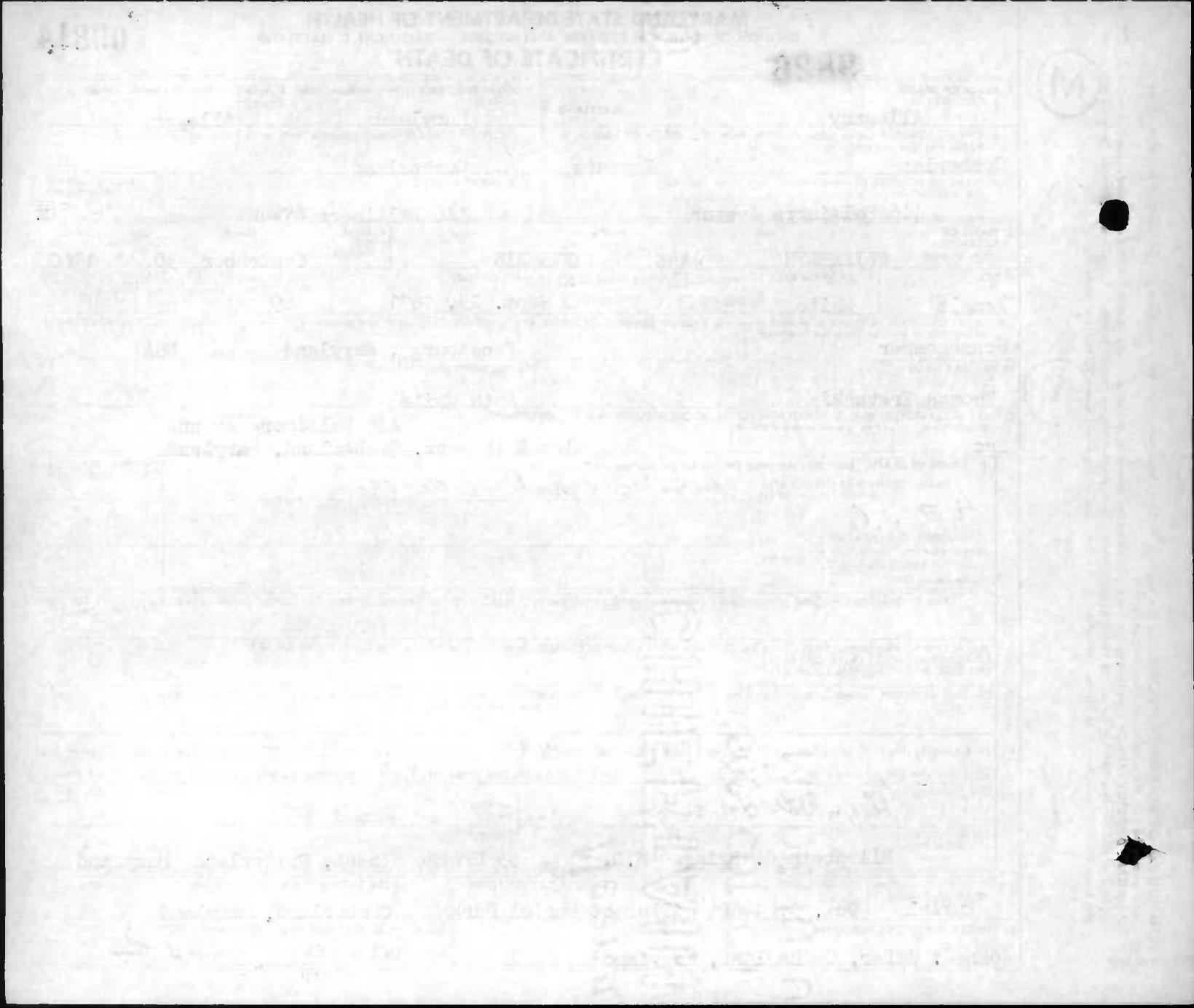
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09814

CERTIFICATE OF DEATH

9826			
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 446 Baltimore Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH JANE TREVASKIS		First Middle Last	4. DATE OF DEATH September 30 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Frostburg, Maryland	
13. FATHER'S NAME Thomas Trevaskis		14. MOTHER'S MAIDEN NAME Ruth White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT 450.0		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 23, 1960</i> to <i>Sept. 30, 1960</i> , that (I) (we) last saw the deceased alive on <i>Sept. 23, 1960</i> , and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Elizabeth G. Brings</i>	
22c. PHYSICIAN'S NAME (Type) Elizabeth G. Brings M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 55 Greene Street, Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS DATE OCT 5 '60 	
		25a. REC'D BY REGISTRAR Arthur S. Kraus	
		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09815

9827

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/14/60			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Jane	Last Ullery		
4. DATE OF DEATH September 21, 1960	Month	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1873		
9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months 86	11. IF UNDER 24 HRS. Hours 86	12. IF UNDER 24 HRS. Min. 86		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) Frenesco, Pennsylvania U. S. A.			
13. FATHER'S NAME Samuel Sherman Diehl	14. MOTHER'S MAIDEN NAME Jane Whetstone				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT P.O. Box 599 Allegany County Infirmary Records	Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration INTERVAL BETWEEN ONSET AND DEATH DUE TO ?					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral arteriosclerosis ? DUE TO ?					
(c) Chronic nephritis ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Smile deterioration 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 9/21/60	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/14/60 19 to 9/21/60 19, that (I) (we) last saw the deceased alive on 9/21/60 19, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE <i>James E. McLean</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/22/60		
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-24-60	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cem.	23d. LOCATION (City, town, or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE SEP 26 '60	25b. REGISTRAR'S SIGNATURE Carroll S. Kraus

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Fig. 7a-d

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CLASSIFICATION

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www.anton.com

Minivans (continued)

www.english-test.net

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ПОДГОТОВКА К ПРОВЕДЕНИЮ ВЫСТАВКИ

Índice temático

Índice temático

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10. *Leucosia* *leucostoma* *leucostoma* *leucostoma* *leucostoma* *leucostoma*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9828

CERTIFICATE OF DEATH

Reg. Dist. No.

09816

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 mos. 5 das.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Brady	Middle 	Last Unger			
4. DATE OF DEATH Sept. 21	Month Sept.	Day 21	Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/83	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Unger		14. MOTHER'S MAIDEN NAME Frances Stotler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Effie Unger, 5 Park St., F'bg.Md.		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic myocardial degeneration INTERVAL BETWEEN ONSET AND DEATH ? 592ax Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450 General arteriosclerosis ? DUE TO (c) 592 Chronic nephritis ? DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 304 Senile psychosis						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg (County) W.M.D. (State) Md.
21. I certify that I attended the deceased from May 16, 1960 to Sept. 21, 1960 , that I last saw the deceased alive on Sept 20th, 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>James E. McLean</i>		ADDRESS (Street, city or town, state) 49 Greene St - DATE SIGNED Sept 26 1960				
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-24-60	22c. NAME OF CEMETERY OR CREMATORIUM F'bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. P. Burst</i>		ADDRESS Frostburg, Md.		24a. REC'D. BY REGISTRAR SEP 26 1960	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinsel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

91 ЗРОДИЛСЯ КОДАМ ВО ТРИНАДЦЯТОЕ СТАРІ ДНЯГІВА

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09817

9844

CERTIFICATE OF DEATH

1. PLACE OF DEATH

o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

1 Month

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

"Rural" Frostburg

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Last

4. DATE OF DEATH

September

30

19 60

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

white

WIDOWED

DIVORCED

9. AGE (In years lost birthday)

88

yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Gilmore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Coleman

14. MOTHER'S MAIDEN NAME

Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Irvin Walters

Address

Lonaconing, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

**PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)**

422.1

**Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.**

DUE TO

(b)

**arteriosclerotic Cardiovascular
disease**

DUE TO

(c)

years

"Son" Cardiac Failure 2 days

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY Month, Doy, Year
Hour o. m. p. m. 19**

**20d. INJURY OCCURRED
While Not while
of work of work**

**20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)**

20f. (City or town)

(County)

(State)

**21. I certify that (I) (this hospital) attended the deceased from Sept 1 1960 to Sept 30 1960 that (I) last
saw the deceased alive on Sept 30 1960 and that death occurred at 2 PM, from the causes and on the date stated above.**

22a. SIGNATURE

John B. Davis,

**ATTENDING
PHYS.**

**MED.
DIRECTOR**

**STAFF
PHYS.**

**22b. DATE
SIGNED
9/30/60**

**22c. PHYSICIAN'S
NAME (Type)**

John B. Davis

22d. ADDRESS

2 Broadwy Frostburg, Md.

**23a. BURIAL, CREMATION,
REMOVAL (Specify)**

**23b. DATE THEREOF
Burial 10/2/60**

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town, or county)

(State)

Frostburg

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

**25a. REC'D BY REGISTRAR
DATE OCT 3 '60**

25b. REGISTRAR'S SIGNATURE

George Eichhorn Lonaconing, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G271 9-13-60 et

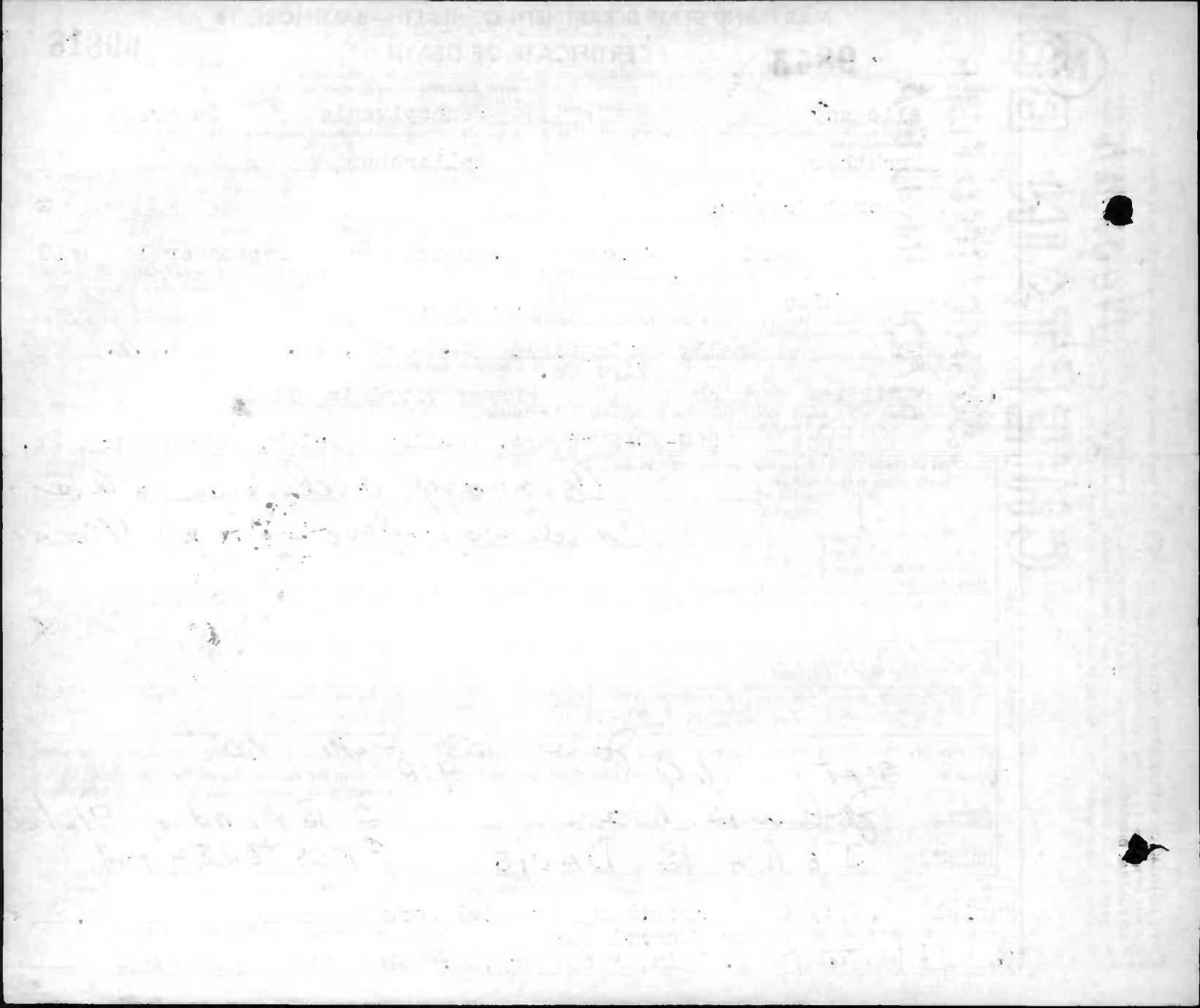
9845

CERTIFICATE OF DEATH

Reg. Dist. No.

09818

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners' Hospital	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wellersburg		e. STREET ADDRESS 19X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Carl	Middle Mason	Last Warnick
4. DATE OF DEATH	Month September	Day 1	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1904
9. AGE (In years last birthday) 56 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker	11. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Tire Co.	12. BIRTHPLACE (State or foreign country) Huntington, Pa.
13. FATHER'S NAME Joseph William Warnick	14. MOTHER'S MAIDEN NAME Laura Virginia Willis	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Pauline Warnick, Wellersburg, Pa.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary occlusion 8 hrs Cardiovascular disease years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Sept 1, 1958 to Sept 1, 1960 and that I lost sight of the deceased alive on Sept 1, 1960 and that death occurred at 9 ipm , from the causes and on the date stated above.	
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.	
PHYSICIAN'S NAME (Type) John B. Davis		DATE SIGNED 9/2/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/4/60	22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg
23. FUNERAL DIRECTOR'S SIGNATURE Benj H. Whiteside	ADDRESS 23 E. Main, Frostburg, Md.	24a. REC'D BY REGISTRAR SEP 7 '60	24b. REGISTRAR'S SIGNATURE John S. Hafer



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9824

09819

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS 500 OLDTOWN ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ARTHUR	Middle J.	Last WEBER	4. DATE OF DEATH SEPTEMBER 8 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUGUST 28, 1885	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Dots Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sident		10b. KIND OF BUSINESS OR INDUSTRY SOUTH CUMBERLAND PLANING MILL		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME LOUIS WEBER		14. MOTHER'S MAIDEN NAME Anna CATHERINE BOPP		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-8398		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 490X		36 Bar Macomber		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)		Cervical Disc Herniation Osteoarthritis		3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1960 to Sept. 1960, that (I) (we) last saw the deceased alive on Sept. 8, 1960, and that death occurred at 3:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>J. O. Himmelwright</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 9/8/60	
22c. PHYSICIAN'S NAME (Type) DR. J. O. Himmelwright		22d. ADDRESS 1334 Avenue, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-10-60		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Knudsen					

6120

HEADS TO HAWTHORPE

STANSLY

GRAYHAWK

WILDELLA

DALESTON

SYBIL

WILDELLA

DICK WOTTON DOG

BATTISON MIRESH

ROBERT C. HOWE

REHM

ROBERTA

ROBERT TUDOR

ROBERT

ROBERT WATSON - JANE DILLON - ROBERT WATSON

ROBERT WATSON

ROBERT WATSON

ROBERT WATSON - JANE DILLON - ROBERT WATSON

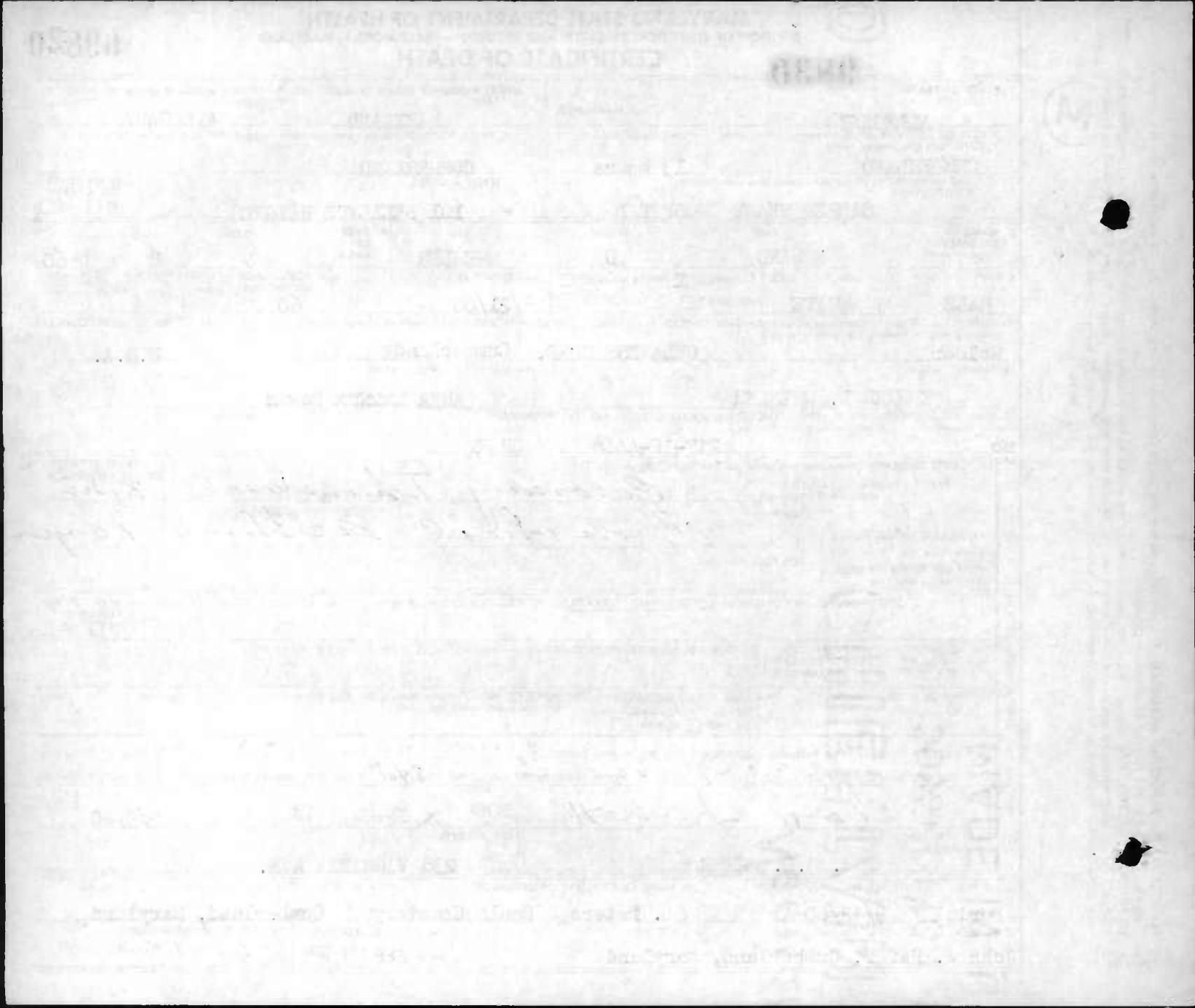
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

69820

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		f. STREET ADDRESS 101 BELLEVUE HEIGHTS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD		First D	Middle WHEELER	Last WHEELER	4. DATE OF DEATH 9 8 1960	Month 9	Day 8	Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/00	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EDWARD L. WHEELER		14. MOTHER'S MAIDEN NAME ANNA BROWN Rowan				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-4446		17. INFORMANT CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 24 IX		<i>Coronary Thrombosis</i>				8 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b)		<i>Pneumocidal asthma</i>				1 day			
DUE TO 24 IX									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>lying cause last.									
DUE TO 24 IX									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 19 60 to Sept 8 1960		(County) 9/9/60	
								(State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 60 to Sept 8 1960 , that (I) (we) last saw the deceased alive on Sept 7 1960 . And that death occurred at 8:45 AM from the causes and on the date stated above.									
22a. SIGNATURE Edward L. Durrett		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/9/60		
22c. PHYSICIAN'S NAME (Type) DR. C.E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters & Pauls Cemetery		23d. LOCATION (City, town, or county) Cumberland, Maryland			(State)
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kress			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 300 N. Waverly Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF -DECEASED (Type or print)	First John	Middle M.	Last Whetzel	4. DATE OF DEATH Sept. 15 1960	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1906	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Mathias, W. Va.	
13. FATHER'S NAME Joseph Whetzel		14. MOTHER'S MAIDEN NAME Lula Strawderman		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-1049		17. INFORMANT Address Mrs. John Whetzel, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRAPERICARDIAL HEMORRHAGE DUE TO Pending 1 Hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RUPTURE OF DISSECTING ANEURYSM OF AORTA DUE TO 1 Hr.					
(c) DISSECTING ANEURYSM; TRAUMATIC DUE TO 1 Month.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) TRUCK FELL OFF JACK COMPRESSING CHEST					
20c. TIME OF INJURY Hour 2:30 p.m.		Month, Day, Year Aug. 15 1960	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage	20f. (City or town) (County) (State) Cumberland, Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			ADDRESS	24a. REC'D BY REGISTRAR SEP 21 '60	24b. REGISTRAR'S SIGNATURE <i>Cather S. Kline</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or a burial or cremation, or removal.

VS. A15ME(5)
5M 9/55

87 REGIONS-MADE EQUAL IN THE STATE OF OKLAHOMA
BY THE STATE OF OKLAHOMA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

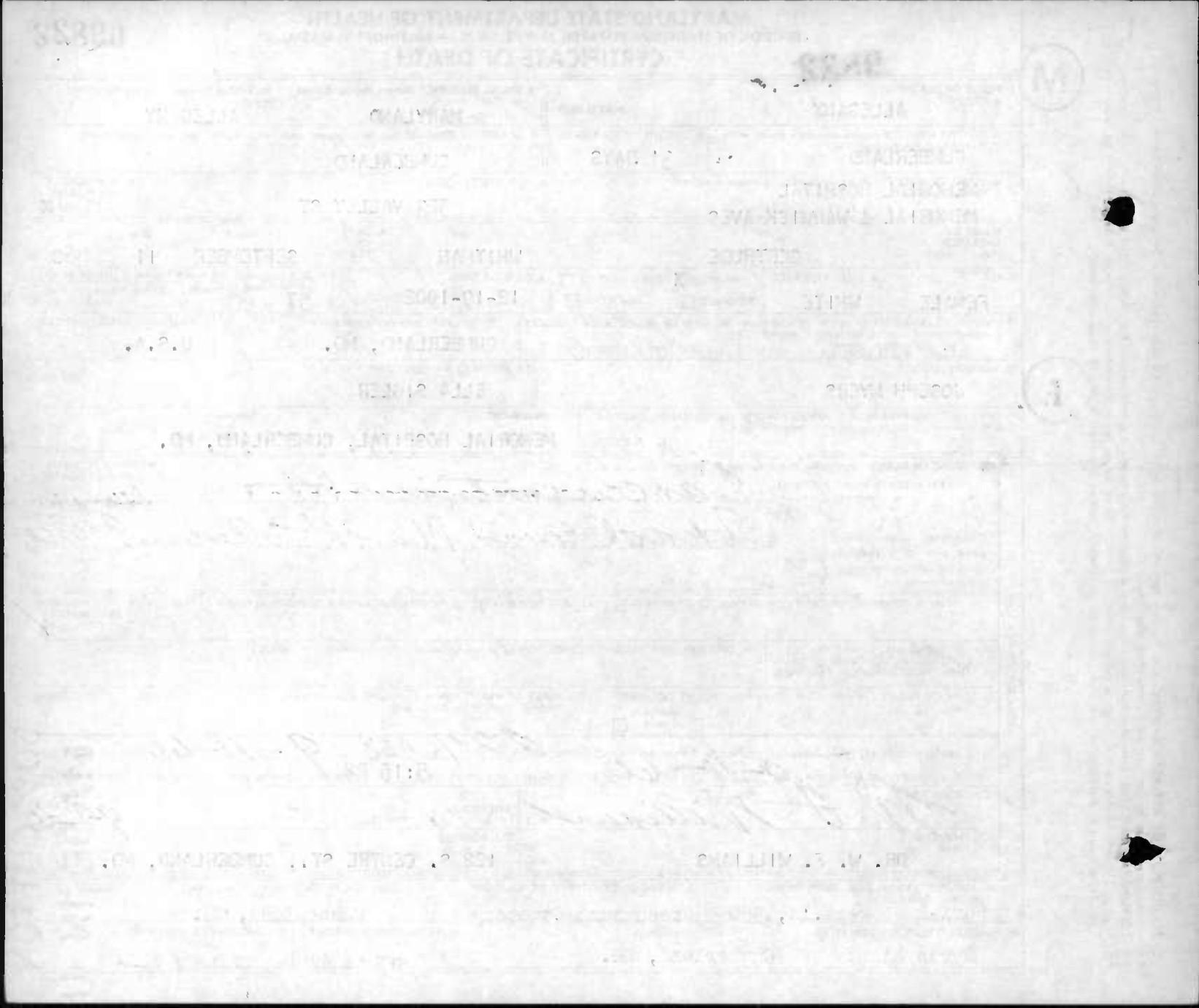
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

19822

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 31 DAYS	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) CONSTITUTIONAL HOSPITAL MEMORIAL & WARWICK AVES		d. STREET ADDRESS 1 523 VALLEY ST			
3. NAME OF DECEASED (Type or print)	First GERTRUDE	Middle	Last WHITMAN		
4. DATE OF DEATH			Month SEPTEMBER	Day 11	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1902	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SILK FINISHER		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANERS		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME JOSEPH MYERS			14. MOTHER'S MAIDEN NAME ELLA SIGLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 05 6352		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, pt. DUE TO Brad removed March 5, 1960 INTERVAL BETWEEN ONSET AND DEATH Since Feb. 8					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brad removed March 5, 1960 (c) None					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 227 (County) 9-11-1960 (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1960 to 9-11-1960 that (I) (we) last saw the deceased alive on Sept. 14, 1960 and that death occurred at 5:15 PM , from the causes and on the date stated above.					
22a. SIGNATURE W. F. Williams		ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-12-60	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery	
23d. LOCATION (City, town, or county) Cumberland, Md.				(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight ADDRESS Cumberland, Md.					
25a. REC'D BY REGISTRAR DATE SEP 16 '60				25b. REGISTRAR'S SIGNATURE Byron Kight	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09823

M

9846

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Miners Hospital

d. STREET ADDRESS

134 Bowery Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
Cambria

Middle

Last
Williams4. DATE
OF
DEATH
September 13th, 1960
Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Dots Hours Min.

Male

White

WIDOWED DIVORCED

July 13th, 1897

63 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Self Empl'yd Distrib. Tobacco Bus.

Maryland

USA

13. FATHER'S NAME

Daniel Williams

14. MOTHER'S MAIDEN NAME

Jane Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Charles St., Frostburg, Md.

212-32-8327

Cambria Williams, Jr. Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Metastases

INTERVAL BETWEEN
ONSET AND DEATH

36 hrs.

151X
Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

Carcinomatosis

± 1 yr

DUE TO

(c)

Gastric Antrum Carcinoma ^{wide extension}

± 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus - sudden, severe, post-op

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 1920d. INJURY OCCURRED
While Not while
at work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (his hospital) attended the deceased from 418 1960, to 9113 1960, that (I) (we) last saw the deceased alive on 9113 1960 and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Frank T. Harrat

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

9/15/60

22c. PHYSICIAN'S
NAME (Type)

Frank T. Harrat,

22d. ADDRESS

26 W. Mechanic St., Frostburg, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town, or county)

(State)

Burial

9-16-60

F'lg. Memorial Park

Frostburg,

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

J. P. Ernst

Frostburg, Md.

DATE SEP 19 '60

Signature

2625.0

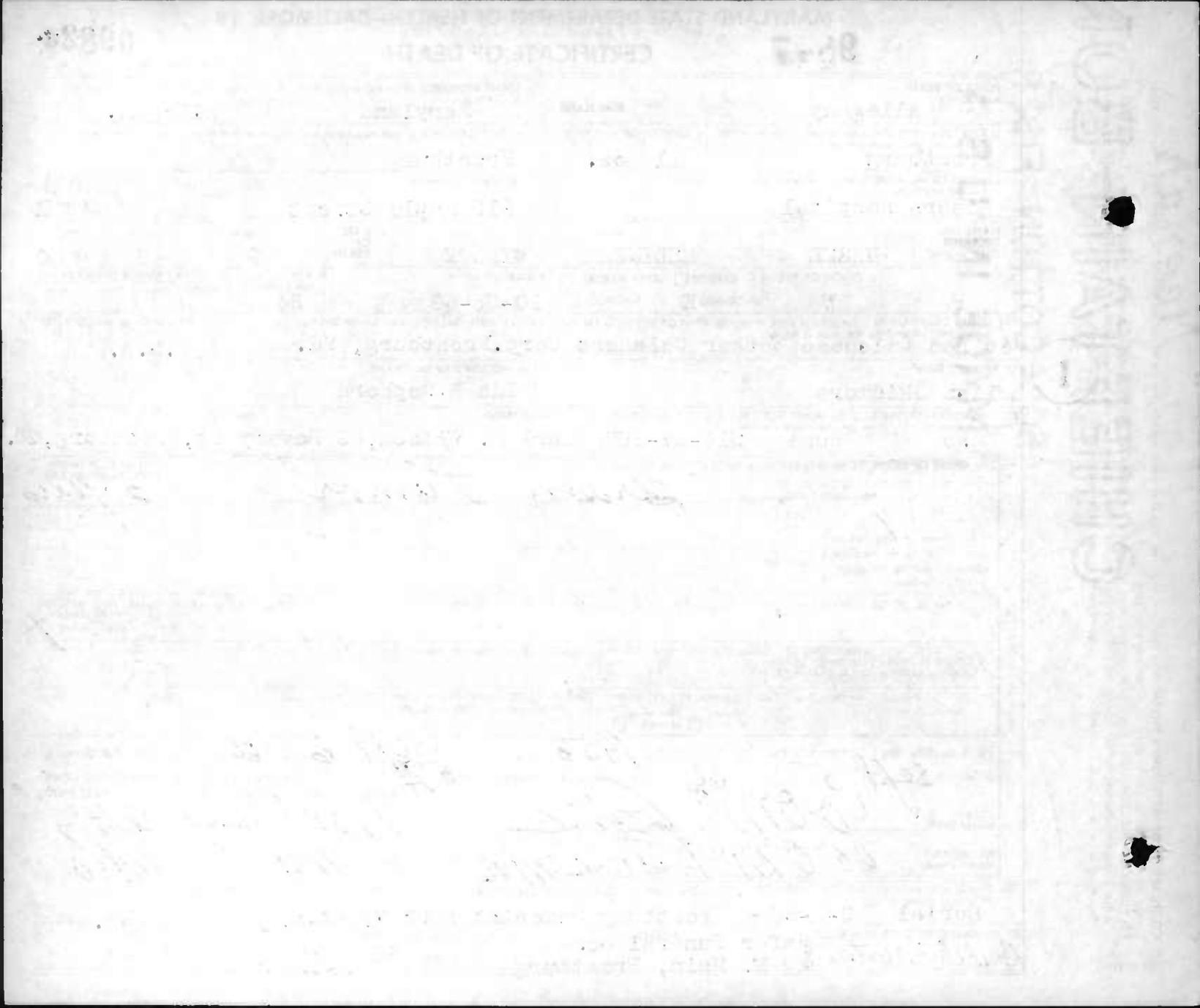
19.20

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item # 9847 1-16-60 et 09824											
CERTIFICATE OF DEATH											
Reg. Dist. No.											
1. PLACE OF DEATH o. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 11 mos.				b. COUNTY Allegany			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				d. STREET ADDRESS 219 Maple Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First HAZEL	Middle MELINDA	Last WILSON	4. DATE OF DEATH Month 9	Day 6	Year 19 60				
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-60 1905		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 54	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Worker				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.				11. BIRTHPLACE (State or foreign country) Frostburg, Md.			
13. FATHER'S NAME Elias Skidmore				14. MOTHER'S MAIDEN NAME Ida B. Rephorn				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Earl H. Wilson, 59 Bowery St, Frostburg, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor INTERVAL BETWEEN ONSET AND DEATH 2 years											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____											
DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		(County) W.M.D.	(State) Md.
21. I certify that I attended the deceased from 1958 , 19, to Sept 6 , 19 60 , that I last saw the deceased alive on Sept 5 , 19 60 , and that death occurred at Frostburg , Md., from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED Sept 6, 1960											
ACTUAL SIGNATURE WOMC											
PHYSICIAN'S NAME (Type) WOMC											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-8-60		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park				22d. LOCATION (City, town, or county) Frostburg		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montesano ADDRESS Hafer Funeral Home											
24a. REC'D BY REGISTRAR DATE SEP 13 '60											
24b. REGISTRAR'S SIGNATURE Carroll S. Trahan											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

109825

9850

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 4 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 Front		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Louis	Middle Elroy	Last Wilson
4. DATE OF DEATH	Month Sept	Day 22	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1916
9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William L Wilson	14. MOTHER'S MAIDEN NAME Elizabeth Lockridge		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. W.W 11	17. INFORMANT Ethel Wilson - Westernport, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Chronic Myocarditis and Myocardial Degeneration not Specified as Rheumatic			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration not Specified as Rheumatic			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 422.2			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Acute cholecystitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from May 12, 1955 , to Sept 22, 1960 , that (I) (we) last saw the deceased alive on Sept. 16, 1960 , and that death occurred at 5A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paula Wilson	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Sept 23, 1960	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.	22d. ADDRESS Piedmont, W. Va.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/24/60	23c. NAME OF CEMETERY OR CREMATORIAL Barnard Cem	23d. LOCATION (City, town, or county) (State) Garrett County Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ed Boal	ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE SEP 26 '60	25b. REGISTRAR'S SIGNATURE Charles S. Kraus

M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09826

Reg. Dist. No.

9858

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOSCOW		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 140 Main	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Donald	Middle Patrick	Last Wilt	4. DATE OF DEATH	Month Sept	Day 7	Year 19 60

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1939	9. AGE (In years (last birthday) 21 yrs.)	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Auto Store		11. BIRTHPLACE (State or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lee O. Wilt		14. MOTHER'S MAIDEN NAME Mary A. Heylmun				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 212-38-5278		17. INFORMANT Mary A. Wilt-Westernport, Md.		Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severed Spinal Cord, Complete		Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 823 X		
DUE TO (b) FRACTURE OF SECOND CERVICAL VERTEBRAE		SUDDEN
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Automobile accident - car off	
20c. TIME OF INJURY Hour 12:05	Month, Day, Year Year Sept 7 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public highway near Moscow Allegany Md
20f. (City or town) Westernport	(County) Allegany	(State) Md.	

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
--	--	--	--

ACTUAL SIGNATURE WOMcLane	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Sept 7 1960
EXAMINER'S NAME (Type) WOMcLane MD ast	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/10/60	22c. NAME OF CEMETERY OR CREMATORIAL Philos	22d. LOCATION (City, town, or county) Westernport	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE El. Beal	ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE SEP 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation, or removal.

V.S. A15ME(5)
5M 9/55

WILDCAT EXAMINER STAFF REPORTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

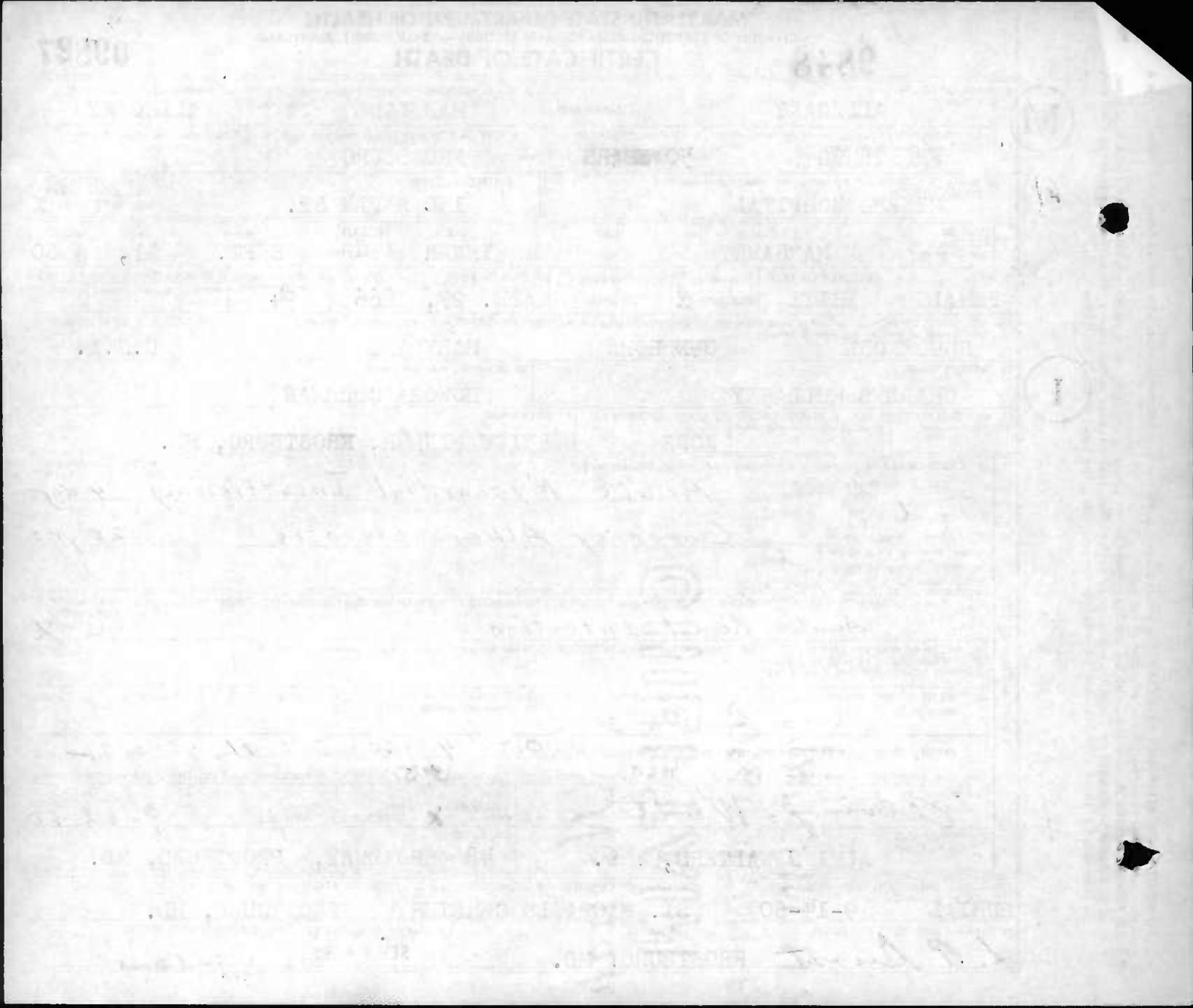
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09827

9848

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 50 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. STREET ADDRESS 150 MAPLE ST.	
3. NAME OF DECEASED (Type or print) MARGARET		First MARGARET	Middle Last WINNER
4. DATE OF DEATH SEPT. 11, 1960	Month SEPT.	Day 11	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 27, 1866
9. AGE (In years last birthday) 94 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME CHARLES MULLANEY	14. MOTHER'S MAIDEN NAME HONORA COLEMAN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT BERNICE WINNER, FROSTBURG, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Acute Myocardial Insufficiency 4 days.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Atherosclerosis		25 yrs.	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Renal Infection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 4 1960 to Oct 11 1960 , that (I) (was) last saw the deceased alive on Oct 4 1960 , and that death occurred 11:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Alvin J. Walters		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-12-60
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-14-60	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAELS CEMETERY
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS FROSTBURG, MD.	23d. LOCATION (City, town, or county) FROSTBURG, MD.
		25a. REC'D BY REGISTRAR DATE SEP 14 '60	25b. REGISTRAR'S SIGNATURE Charles L. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09828

9833

M

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 19 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ELsie	Middle Erma.	Last WINTERS	
4. DATE OF DEATH SEPTEMBER 20	Month SEPTEMBER	Day 20	Year 1960	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 19, 1886	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 74	IF UNDER 1 YEAR Months 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) VA. VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAC ANDERSON	14. MOTHER'S MAIDEN NAME CARRIE CARPER	Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT	18. MEDICAL CERTIFICATION	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cervix with metastasis 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral apoplexy, post-operative DUE TO (c) arterio-sclerotic vascular disease advanced			INTERVAL BETWEEN ONSET AND DEATH approx 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sep 1 1960 to Sep 20 1960 , that (I) (we) last saw the deceased alive on Sep 20 1960 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.				
22a. SIGNATURE <i>DR. WYLIE FAW</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. WYLIE FAW		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town, or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland Md.	25a. REC'D BY REGISTRAR DATE SEP 26 '60	25b. REGISTRAR'S SIGNATURE Charles L. George

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